

## **Credentialing & Privileging – Frequently Asked Questions**

1) What is credentialing?

Credentialing is the process of verifying a provider's education, training, licensure, certification, work history, and professional references to ensure they meet organizational and regulatory requirements.

2) What is privileging?

Privileging is the process of authorizing a provider to perform specific clinical services or procedures based on verified qualifications, experience, and demonstrated competence.

3) What is the difference between credentialing and privileging?

Credentialing confirms who the provider is and that they are qualified; privileging determines what clinical services the provider is authorized to perform.

4) Who completes the credentialing verification?

Primary source verification is conducted by the Credentialing Verification Organization (CVO). The Medical Staff Office reviews the completed file and coordinates privileging approvals.

5) How long does the credentialing and privileging process take?

Timeframes vary based on application completeness, reference response times, and committee meeting schedules. Complete applications generally move more quickly. Our goal is to complete the entire process in 70 days.

6) What documents are required to begin credentialing?

7) Common requirements include:

- a) Completed application
- b) Current professional license(s)
- c) DEA registration (if applicable)
- d) Board certification or eligibility
- e) Professional liability insurance
- f) CV in month/year format
- g) Peer references

8) Why is primary source verification required?

Primary source verification ensures that information is accurate and obtained directly from the original issuing source, as required by accreditation and regulatory standards.

- 9) Can a provider practice before credentialing and privileging are complete?  
Providers may not practice independently until privileges are fully approved.
- 10) Who approves clinical privileges?  
Privileges are reviewed by the Department Chair and Medical Staff leadership and require final approval by the Medical Executive Committee and the Patient Care Committee.
- 11) What happens if information is missing or cannot be verified?  
Incomplete or unverifiable information may delay processing. The Medical Staff Office will notify the provider if additional documentation or clarification is needed.
- 12) How often is recredentialing required?  
Recredentialing occurs every 3 years
- 13) What should I do if my license, insurance, or certification changes?  
Providers are responsible for notifying the Medical Staff Office immediately of any changes that may affect their credentials or privileges.
- 14) How will I know when my privileges are approved?  
Providers will receive written notification once credentialing and privileges have been fully approved and are effective. This comes from the Specialist in the Medical Staff Office.