

Clinician	Planned in-network start	Payers in scope	Owner
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WORKING BACK FROM THE START DATE

WHEN	WHAT TO DO	TARGET DATE	DONE
4–6 months before	Confirm payer targets, network availability, provider eligibility and required documents. Start at the long end if multiple states or complex arrangements are involved.		☐
3–4 months before	Complete CAQH, submit payer applications, record confirmation numbers and status.		☐
2–3 months before	Monitor verification, respond to requests, follow up on outstanding items.		☐
1–2 months before	Check credentialing decisions, contracting and remaining enrollment steps. Escalate unresolved delays.		☐
Before the first in-network service	Confirm the effective date, covered products, provider and group records, and billing setup.		☐
After activation	Verify directory information and monitor the first claims for routing or enrollment issues.		☐

HOW LONG EACH STAGE RUNS

STAGE	PLANNING RANGE	WHAT DELAYS IT
Collect documents, prepare CAQH	A few days to 2–3 weeks	Missing licenses, outdated insurance documents, incomplete work history
Submit payer application	A few days to 2 weeks after preparation	Incomplete forms, incorrect practice details, missing authorizations
Primary-source verification	Roughly 30–60 days in many workflows	Slow responses from licensing boards, institutions or other sources
Committee or designated review	A few days to several weeks	Meeting schedules, unresolved questions, additional review
Contracting and fee schedule	Several weeks in some cases	Negotiation, incomplete contract information, legal review
Enrollment, loading, activation	Days to several weeks	Missing identifiers, group affiliation issues, incomplete payer records

BY PAYER TYPE

Commercial insurance	90–120 days
Medicare enrollment	About 30–60 days for a straightforward electronic application
Medicaid enrollment	About 30–90 days or longer; each state runs its own process
CAQH preparation	A few days to 2–3 weeks when documents are ready
Contracting and final setup	Several weeks in some cases

SEEING PATIENTS BEFORE THE EFFECTIVE DATE

- Possible in some arrangements, but it depends on the payer, the contract, applicable law and how the service is delivered.
- ☐ Confirm status and effective-date rules with the payer first.
 - ☐ Verify the permitted payment arrangement and billing rules.
 - ☐ Check patient disclosure and any state requirements.
 - ☐ Do not represent the clinician as in-network until the payer confirms it.

KEEP THE STAGES SEPARATE

A single status of "in progress" does not say whether a provider is waiting on credentialing approval, a contract, or final billing setup. Track and ask about each one by name.

ALL SIX MUST BE TRUE BEFORE THE FIRST IN-NETWORK CLAIM

☐ Credentialing approval confirmed by the payer

☐ Participation agreement finalized where required

☐ Provider, group, tax ID and service locations recorded correctly

☐ Effective date confirmed in writing

☐ The specific product and network the patient holds is covered

☐ Billing identifiers and claims requirements verified

Stages overlap, so the total is not the sum. Some activities run in parallel; adding the ranges above together will overstate the timeline as often as it understates it.

Ask a specific question. "Credentialing appears approved — is the contract finalized, is the provider record active for billing, and what effective date is on file?" gets a more useful answer than asking whether someone is credentialed.

Start at least 90–120 days out for a commercial launch, and earlier when several payers or states are involved. Backdating is not a remedy: confirm the payer's rules before assuming that services delivered before the effective date will be paid at in-network rates.