

INSURANCE CREDENTIALING · MEDICARE, COMMERCIAL PLANS, MEDICAID

Getting in-network as a dietitian

What to have ready, the order to file in, where each payer takes applications, how long it runs, and what to set up the day you are approved.

Read this first

Credentialing (the payer verifies you) and contracting (your rates and effective date) are two steps. Timelines here are what a payer publishes or a planning range, and they vary: **ask the payer**. Wherever this sheet says verify, it means it.

1 What to have ready before the first application

One folder, one spelling of every fact

ITEM	WHAT IT IS	WATCH FOR
NPI Type 1	Your individual NPI, free from NPPES (nppes.cms.hhs.gov).	Update NPPES within 30 days of any change.
NPI Type 2 IF A GROUP	Only if you bill through an LLC, PLLC or group (its EIN).	Claims then carry both: billing and rendering NPI.
Taxonomy	133V00000X Dietitian, Registered (NUCC); 133VN... if board-certified.	The same code on NPPES, CAQH and every payer file.
License · CDR	State license in each state your patients are in; RD/RDN number.	Licensure follows the patient, not you.
Malpractice COI	Current face sheet: carrier, dates, limits.	Many payers ask for \$1M / \$3M: check each contract.
W-9 · TIN	Your SSN as an individual, or the entity's EIN.	Legal name and TIN identical everywhere.
CV / work history	Month and year for every role, degree and training.	Explain every gap in writing before anyone asks.
Practice address	Physical location (no P.O. box), phone, an email you read.	Medicare lets a telehealth-only home office hide it.
Bank info for EFT	Voided check or bank letter for direct deposit.	Medicare pays only by EFT (form CMS-588).
CAQH profile	Free Provider Data Portal (was ProView; CAQH is now DataSpring).	Attest every 120 days (180 in IL); authorize each payer.
Medicare login	I&A login for PECOS, or paper CMS-855I (855R merged in 2023).	Group: CMS-855B, and each RD reassigns to it.

2 The order, and what can run at the same time

WEEK 0 Identity

NPI(s) with 133V00000X, then the folder above. One time.

>

WEEK 1 CAQH

Complete, attest, and authorize every payer you'll apply to.

>

THEN Apply, in parallel

Medicare, each commercial payer and state Medicaid at once, not one by one.

>

EACH Follow up

Verification, committee, contract. Every 2-3 weeks; log names and dates.

>

APPROVED Set up

Effective date in writing; ERA, EFT and claim enrollment (\$6).

3 How long it takes, by payer

Varies — ask the payer. Payer clocks start at a complete application.

PAYER	WHAT THE PAYER OR THE RULE SAYS	PLAN FOR
Medicare (PECOS)	CMS's standard for its MACs: 95% of PECOS applications in 15 days, or 50 if the MAC asks you for more.	1-3 months
UnitedHealthcare	"Up to 45 calendar days or more" once UHC has a complete application.	2-4 months
Cigna	"Typically takes 45 to 60 days"; then about 10 business days to load you into claim systems.	2-4 months
Aetna	Decides on your request to participate within 60 days; credentialing from CAQH follows.	2-4 months
BCBS local plan	Each Blue plan is its own company with its own timeline: ask yours.	2-4 months
Humana	Medicare-only providers joining a non-delegated group: in network 30 days after all documents are in.	2-4 months
Medicaid + MCOs	State enrollment first, then each MCO (it may contract up to 120 days while that is pending).	2-4+ months

"Plan for" is our range from application to a usable effective date, contracting included: not a payer promise.

4 The in-network effective date: don't bill before it

- **What it is:** the first date of service the payer pays you in network. Not the day you applied, the approval email or the day you signed.
- **Get it in writing** with the countersigned contract, then confirm with provider services that your NPI, TIN and location are loaded.
- **Before it:** see patients cash-pay (a superbill if they want one), or book insurance visits after the date. A claim for an earlier date usually comes back **CO-B7**.

Retroactive billing: the rules differ

- **Medicare:** the effective date is the later of the day you filed an approved application or the day you started at that location. You can bill up to **30 days before** it if circumstances kept you from enrolling first (42 CFR 424.520(d), 424.521(a)).
- **Commercial and Medicaid plans:** set by the contract or the state. Many don't backdate at all. Ask during contracting, and never count on it.

Medicare has its own MNT rules once you are enrolled: diabetes, non-dialysis kidney disease or a kidney transplant in the last 36 months, a referral from the treating physician (MD/DO), hour limits per calendar year, and you must accept assignment. Full rules: farela.ai/blog/medicare-mnt-billing-guide.

5 Payer by payer: where to apply

Portal names from each payer's own site, September 2026

PAYER	WHERE TO APPLY	WHAT TO KNOW AS AN RD
☐ Medicare Part B	PECOS with an I&A login (or paper CMS-855I), processed by your state's MAC. EFT on CMS-588.	Enroll as a registered dietitian/nutrition professional; you must accept assignment on MNT. One enrollment per state where you see patients. Revalidate every 5 years.
☐ BCBS (your local plan)	Your local Blue plan's provider site: it names its own portal and forms.	Each Blue plan is a separate company. BlueCard : out-of-state Blue members are billed to your local plan, and your network status comes from that local contract.
☐ Aetna	The request for participation form on "Join the Aetna network" (aetna.com). Aetna then pulls your CAQH application.	Authorize Aetna in CAQH. Aetna Better Health is Medicaid, and Medicare Advantage is its own product: verify which ones your contract covers.
☐ UnitedHealthcare	Onboard Pro , in the UnitedHealthcare Provider Portal. Have your CAQH ID and TIN ready.	Recredentials on a 3-year cycle and starts it for you if you attest your data every 90 days. Optum Behavioral Health is a separate network, not the route for MNT.
☐ Cigna	Call Provider Services, 1-800-88CIGNA (882-4462), to confirm you meet the guidelines; the application arrives by email.	Cigna reads your CAQH profile with your permission. At recredentialing it emails you to update and re-sign CAQH.
☐ Humana	"Join our network" on provider.humana.com: an online form in 11 states, elsewhere an email to your regional representative.	Requires CAQH, with access granted to Humana. It left employer commercial plans in 2025: members are mostly Medicare Advantage and Medicaid.
☐ State Medicaid	Your state Medicaid agency's provider enrollment portal, then each managed care plan (MCO).	Not every state enrolls dietitians or covers MNT: verify first. MCOs must use providers the state has enrolled (42 CFR 438.602(b)).

6 After approval: before the first claim, and every year after

Before the first claim

- ☐ **Contract, effective date and fee schedule** for 97802, 97803 (and 97804 for groups) in hand. Ask for the fee schedule before you sign.
- ☐ **Loaded in the payer's system**: call provider services and confirm it for the plan types you will see.
- ☐ **Clearinghouse enrollments, per payer**: claims where the payer requires it, and ERA (the 835 remittance). In Claim.MD these are its payer enrollments; some need a signed form.
- ☐ **EFT, per payer**: through the payer or the vendor it names; Medicare's is CMS-588 with your MAC. Without ERA and EFT, payments arrive as paper you match by hand.

On the calendar, for good

- ☐ **CAQH attestation** every 120 days (set 110). Re-attest after any change, and upload each new malpractice face sheet and license renewal.
- ☐ **Recredentialing** with each payer, at least every 3 years (NCQA's standard is 36 months). Ignoring the notice can drop you from the network.
- ☐ **Medicare revalidation** every 5 years. Report a new practice location within 30 days and other changes within 90.
- ☐ **Payer-specific cycles**: UHC says a complete, current data attestation every 90 days keeps its recredentialing automatic. Ask each payer for its own.

7 Common mistakes and the denials they cause

Full guides at farela.ai/denials

MISTAKE	WHAT HAPPENS	FIX
Name, address or TIN differ across NPPES, CAQH, license, W-9 and the application	The file stalls in verification; later, claims reject or come back CO-16 (missing or invalid information).	One canonical spelling. Fix NPPES and CAQH first, then tell each payer.
Wrong or missing taxonomy , or a specialist code you don't hold	The payer can't match you to a dietitian: CO-170 (not payable to this provider type).	133V00000X on NPPES, CAQH and the claim, unless you are board-certified.
Billing before the effective date , or after a license, enrollment or CAQH lapse	CO-B7 : provider not eligible on this date of service.	Bill only from the effective date in writing; keep renewals on the calendar (§6).
Seeing a plan you aren't contracted for (an HMO/EPO product, Medicare Advantage, a Medicaid MCO)	CO-242 : services not provided by network providers.	Ask on the benefits check which product the member has, and whether your contract covers it.
No ERA or EFT enrollment	Claims pay, but by paper check with a paper EOB, so payments are slow to post and easy to lose.	Enroll ERA and EFT for each payer the day you are approved (§6).
Lapsed CAQH attestation	New applications and recredentialing stop without notice.	Attest every 120 days; check CAQH first when a file goes quiet.

Made by Farela

A free EHR for dietitians: it records the session, writes the note and builds the claim you submit through your own Claim.MD account. Then it reads the remittance and explains the denial codes on it.

Try Farela free →

farela.ai

Not legal or credentialing advice. Payers change their processes, portals and timelines. Always confirm with the payer, your contract and your state before you apply or bill. Farela does not credential you or submit applications or claims for you. Farela is not affiliated with CMS, DataSpring (CAQH) or any payer named here.

Sources: CMS: 42 CFR 424.515, 424.516(d), 424.520(d), 424.521(a); Medicare Claims Processing Manual Ch. 4 §300.3 (RD enrollment, assignment); Program Integrity Manual Ch. 10 §10.5 (MAC processing standards); CMS-855I (05/23) consolidation bulletin; CMS-588; MLN901705 Telehealth (Dec 2025). 45 CFR 162.410 (NPPES updates). NUCC Health Care Provider Taxonomy v26.1. DataSpring (CAQH) Provider Data Portal FAQs. UHC: "Join our network – Medical providers" and Onboard Pro. Cigna: Credentialing. Aetna: Join the Aetna network. Humana: Join our network; Credentialing (CAQH). Humana 2025 Form 10-K. 42 CFR 438.602(b) (Medicaid MCO enrollment). NCQA Credentialing standards (36-month recredentialing). X12 Claim Adjustment Reason Codes.