HealthCare Partners, IPA
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RE-CREDENTIALING APPLICATION
READ BEFORE YOU PROCEED

Practitioner Name: _____

Practitioner's CAQH#: _____

IMPORTANT: Failure to respond to our request for the re-credentialing documentation will result in the termination of your participation from all HCP delegated networks at the end of your re-credentialing cycle

Please be sure you have re-attested to your information in the last 120 days and all information on CAQH is correct and current.

To avoid delay in processing your application, include the following documents when returning your credentialing package:

HealthCare Partners Forms (included in our package):

- **Active Office Location form –** include the office locations where you will be seeing HCP members *(be sure all offices listed are found on your CAQH application)*
- **Site Assessment Tool –** complete this form for each office location you listed on the Active Office Location form
- **Primary Care Provider Office Hours –** must be completed by ALL PCPs
- **Covering Practitioner Form**
- **NYS Medicaid Form** (completed and signed)
- **Conflict of Interest Disclosure Statement** (completed and signed)

Copies of Documents (if not available and current on CAQH):

- **Malpractice Insurance Certificate**
- **DEA Certificate (if *applicable)***

Send Completed Documents to:
Fax: 516-515-8843
OR
Email: Credentialing@hcpipa.com

Note: as a participating provider with HCP IPA, you have the following practitioner rights: The right to review information submitted to support your credentialing application, correct erroneous information, and upon your request, be informed of the status of your application.

501 Franklin Ave, Suite 300
Garden City, NY 11530
(888) 746 - 2200
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ACTIVE OFFICE LOCATIONS

Practitioner Name: _____
(Please Print)

IMPORTANT NOTICE: Please list **ALL locations** where the provider currently sees HealthCare Partners members. This form should include **ALL GROUPS** provider is affiliated with**.** *Locations not listed on this form will be deleted from the provider's profile with HealthCare Partners, IPA.*

Primary **Office Address:** _____
_____

Secondary **Office Address:**_____
_____

Additional **Office Address:**_____
_____

Additional **Office Address:**_____
_____

Additional **Office Address:**_____
_____

Additional **Office Address:**_____
_____

*Please be sure **all** locations listed above are included on your CAQH or HCP application.*

For additional locations or groups, please photocopy this form.

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SITE ASSESSMENT TOOL

Please complete a form for each ACTIVE office location
(Be sure to make additional copies, one for each location)

Practice Name: _____
Street: _____
City/State/Zip Code:_____
Office Phone#: _____ **Office Fax #:** _____ **Tax ID #:** _____

NOTE: For any **NO** response, please provide an explanation on a separate sheet of paper.

AMERICAN DISABILITY ACT (view at **ada.gov/racheck.pdf**)

1. Does this office meet ADA accessibility requirements? ☐ **YES** ☐ **NO**

PHYSICAL ACCESSIBILITY

2. Facility entry is handicapped accessible? ☐ **YES** ☐ **NO**
3. Bathrooms are handicapped accessible? ☐ **YES** ☐ **NO**
4. Exam Tables are handicapped accessible? ☐ **YES** ☐ **NO**
5. Office Hours are posted in office? ☐ **YES** ☐ **NO**

PHYSICAL APPEARANCE

6. Floors, walkways, rooms, entrances and exits are clean and free of clutter? ☐ **YES** ☐ **NO**
7. Bathrooms and hand washing areas have hot water, soap and paper towels/air dryers? ☐ **YES** ☐ **NO**
8. Sufficient lighting (indoors and outdoors)? ☐ **YES** ☐ **NO**
9. Fire extinguishers, smoke detectors and sprinklers are present, accessible and in working order? ☐ **YES** ☐ **NO**
10. Evacuation plan and/or EXIT sign is displayed? ☐ **YES** ☐ **NO**

ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS

11. Adequate seating in waiting room (3 chairs per physician)? ☐ **YES** ☐ **NO**
12. Exam room equipped with adequate space/privacy? ☐ **YES** ☐ **NO**

ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING

13. Medical records are filed securely, easily accessible and limited to authorized personnel? ☐ **YES** ☐ **NO**
14. All entries are legible, signed and dated? ☐ **YES** ☐ **NO**
15. HIPAA Privacy Notice is visibly displayed and distributed to all patients? ☐ **YES** ☐ **NO**

I, the undersigned, attest that the information on this form is complete and accurate.

_____ _____
Signature and Title of Authorized Personnel **Date**

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Primary Care Provider's OFFICE HOURS

To be completed by ALL Primary Care Providers

*Per NYS Medicaid MCO guidelines all PCPs **must** have a minimum of 16 hours per location per week and up to a maximum of 48 hours total per week between all locations.* ***Hours cannot overlap between locations.***

Primary office address:_____
_____

M ___-___ T ___-___ W ___-___ TH ___-___ F___-___ SAT ___-___ SUN ___-___

Secondary office address: _____
_____

M ___-___ T ___-___ W ___-___ TH ___-___ F___-___ SAT ___-___ SUN ___-___

Additional office address:_____
_____

M ___-___ T ___-___ W ___-___ TH ___-___ F___-___ SAT ___-___ SUN ___-___

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COVERING PRACTITIONER FORM

Dear Practitioner:

In order to participate in the HealthCare Partners, IPA Network you must have coverage arrangements to assure that services are available on a twenty-four-hour-a-day, seven-days-a-week basis. Covering providers should be the same or similar specialty and be participating with HealthCare Partners or an affiliated health plan.

STEP 1: Please complete the next four lines with "Your" information:

Print Provider Name: _____

Provider's Specialty:_____

Date Signed:_____

Authorized Signature:_____

STEP 2: Please complete the grid below with the information of the provider(s) who will cover for you:

Name	Specialty	Address	Phone #

□ I am available 24 hours a day, 7 days a week via my answering service arrangements.

Please submit this form with your credentialing/re-credentialing application

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NYS MEDICAID REQUIREMENT

Effective January 1, 2018, Federal law requires that all Medicaid Managed Care and Children´s Health Insurance Program network providers be enrolled with State Medicaid programs.

Please supply your NYS Medicaid Program number (MMIS- Maintenance Management Information System):

Name:_____
(Please print legibly)

MMIS:_____

I DO NOT have a NYS MMIS number

I, _____, therefore understand that I will not be able to service Managed Medicaid or Children's Health Insurance Program members and thus will not be part of the HealthCare Partners Medicaid Network.

By signing below, you certify that the information you provided is true and accurate to the best of your knowledge.

Signature: _____ Date: _____

Print Name: _____

***If it is determined by HealthCare Partners (HCP) that you do have an active NYS MMIS number, you will be included in the HCP Managed Medicaid Network in accordance with your contractual obligations.**

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HCP Provider Conflict of Interest Disclosure Statement

I, _____, hereby declare that:

☐ I (or my immediate family) **do not** have an actual, potential or perceived Conflict of Interest (i.e., financial interest, outside position, business relationship or compensation arrangement, or other circumstance) that may impact my professional responsibility.

☐ I (or my immediate family) have an actual, potential or perceived Conflict of Interest that I hereby disclose to HealthCare Partners, IPA, including where compensation is related to the volume of procedures.*

*If you indicated that you do have a Conflict of Interest, please include the additional detail where appropriate below (use additional paper if necessary).

Additional Disclosure Detail

Legal name of the entity involved: _____

Entity's principal line(s) of business:_____

Provider's outside role, if any (e.g., title): _____

Business address:_____

Federal Tax ID number: _____

Provider's ownership interest, if any (e.g.; type, dollar value and percentage): _____

_____

By signing below, I attest that:

☐ I have read, understand, and agree to comply with Healthcare Partners, Conflict of Interest and Acceptance of Gifts Policy accessible via https://www.HealthCarePartnersNY.com/; and **I agree to disclose any actual, potential or perceived conflict of interest during the credentialing and re-credentialing period, and at any other time a Conflict of Interest may arise**.

Signature: _____ Date: _____

Print Name: _____

Title:_____

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