

# 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)**
- **W-9 form for each Tax ID#**

**Send Completed Documents to:  
Fax: 516-515-8843  
OR  
Email: [Credentialing@hcpipa.com](mailto: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.*

## 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.*

# 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](http://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**

## Request for Taxpayer Identification Number and Certification

**Give form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



# 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	__	-	__
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Secondary office address: \_\_\_\_\_  
\_\_\_\_\_

M	__	-	__	T	__	-	__	W	__	-	__	TH	__	-	__	F	__	-	__	SAT	__	-	__	SUN	__	-	__
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Additional office address: \_\_\_\_\_  
\_\_\_\_\_

M	__	-	__	T	__	-	__	W	__	-	__	TH	__	-	__	F	__	-	__	SAT	__	-	__	SUN	__	-	__
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501 Franklin Ave, Suite 300  
Garden City, NY 11530  
(888) 746 – 2200  
HealthCarePartnersNY.com



# 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: \_\_\_\_\_

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### 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.**



# 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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