HealthCare Partners

Re-credentialing Application

PLEASE READ – Please be sure you have re-attested your CAQH within the last 120 days and all information is correct and current.

Be sure to include the following when returning your application:

HCP Documents:

Conflict of Interest Disclosure

Provider Documents (if not available and current on CAQH):

Malpractice Insurance Certificate W-9 form for each Tax ID#

> Return completed documents to: Email: credentialing@hcpipa.com Fax: 516-515-8843

Provider Information						
Provider Last Name:	Provider First Name:					
Title/Degree:	CAQH#:					
Covering Practitioner						
You must have coverage arrangements to assure that services are available on a 24/7 basis						
Name of covering provider:						
Provider's Specialty:						
Covering Provider Address:						
Phone#:						
OR, by checking the below box:						
I attest that I am available 24 hours a day, 7 days a week						
via my answering service arrangements						
Affiliations						
Does provider belong to another IPA?	If yes, please indicate IPA:					
Yes No						
Does provider belong to an ACO?	If yes, please indicate ACO:					
Yes No						

Primary Location								
Practice Name:								
Tax II	D#:	EMR System Name:						
Street Address:								
City,	State:	Zip:						
Phon	e#:	Fax#:						
<u>Office Hours</u> Primary Care Physicians ONLY (Internal Medicine, Family Medicine, Family Practice, Pediatrics)								
Require a minimum 16 hours per location per week, maximum 48 hours between all locations. Hours cannot overlap								
Mon	to	Tues _		_to				
Wed	to	Thurs _		_ to				
Fri	to	Sat		_to				
Sun	to							
<u>Site Assessment</u>								
	ican Disability Act:							
 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					

Please complete this page for each additional office location the provider practices at

Additional Location								
ice Name:								
x ID#: EMR System Name:								
t Address:								
State:	Zip:							
e#:	Fax#:							
<u>Office Hours</u> Primary Care Physicians ONLY (Internal Medicine, Family Medicine, Family Practice, Pediatrics)								
Require a minimum 16 hours per location per week, maximum 48 hours between all locations. Hours cannot overlap								
to	Tues _		_ to					
to	Thurs		_to					
to	Sat _		_to					
to								
Sunto Site Assessment								
ican Disability Act:								
1. Does this office meet ADA accessibility		Vee	No					
•		TES						
			Νο					
		Yes						
	ice Name: p#: t Address: State: e#: f(Internal Medicine, Family Medi Require a minimum per week, maximum 48 he Hours can to to to	ice Name: D#: EMR System Address: State: State: Coffice Hours Primary Care Physicians (Internal Medicine, Family Medicine, Fam Require a minimum 16 hours per week, maximum 48 hours betw Hours cannot overla to to Tues to Tues to Sat to Sat to Sat Thurs Contended Contend	ice Name: EMR System Name D#: EMR System Name t Address: Zip: State: Zip: e#: Fax#: Office Hours Primary Care Physicians ONLY (Internal Medicine, Family Medicine, Family Practice Require a minimum 16 hours per locatio per week, maximum 48 hours between all loca Hours cannot overlap	ice Name: D#: EMR System Name: Address: State: State: Cip: Fax#: Cip: Primary Care Physicians ONLY (Internal Medicine, Family Medicine, Family Practice, Pediatrics) Require a minimum 16 hours per location per week, maximum 48 hours between all locations. Hours cannot overlap to				