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? ☐ Yes ☐ No	**If yes, please indicate IPA:**
Does provider belong to an ACO? ☐ Yes ☐ No	**If yes, please indicate ACO:**

Primary Location	
Practice Name:	
Tax ID#:	**EMR System Name:**
Street Address:	
City, State:	**Zip:**
Phone#:	**Fax#:**

Office Hours 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 _____	

Site Assessment

American Disability Act:

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 ☐

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

Additional Location	
Practice Name:	
Tax ID#:	**EMR System Name:**
Street Address:	
City, State:	**Zip:**
Phone#:	**Fax#:**
Office Hours **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 _____**
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