

# Re-credentialing Application

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

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**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#

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**Return completed documents to:  
Email: [credentialing@hcpipa.com](mailto:credentialing@hcpipa.com)  
Fax: 516-515-8843**

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

<b><u>Primary Location</u></b>	
<b>Practice Name:</b>	
<b>Tax ID#:</b>	<b>EMR System Name:</b>
<b>Street Address:</b>	
<b>City, State:</b>	<b>Zip:</b>
<b>Phone#:</b>	<b>Fax#:</b>
<b><u>Office Hours</u></b> <b>Primary Care Physicians ONLY</b> <b>(Internal Medicine, Family Medicine, Family Practice, Pediatrics)</b>	
<b>Require a minimum 16 hours per location                      per week, maximum 48 hours between all locations.                      Hours cannot overlap</b>	
<b>Mon</b> _____ <b>to</b> _____	<b>Tues</b> _____ <b>to</b> _____
<b>Wed</b> _____ <b>to</b> _____	<b>Thurs</b> _____ <b>to</b> _____
<b>Fri</b> _____ <b>to</b> _____	<b>Sat</b> _____ <b>to</b> _____
<b>Sun</b> _____ <b>to</b> _____	
<b><u>Site Assessment</u></b>	
<b><u>American Disability Act:</u></b>	
1. Does this office meet ADA accessibility requirements?	Yes      No
<b><u>Physical Accessibility:</u></b>	
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

<b><u>Additional Location</u></b>	
<b>Practice Name:</b>	
<b>Tax ID#:</b>	<b>EMR System Name:</b>
<b>Street Address:</b>	
<b>City, State:</b>	<b>Zip:</b>
<b>Phone#:</b>	<b>Fax#:</b>
<b><u>Office Hours</u></b> 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 _____	
<b><u>Site Assessment</u></b>	
<b><u>American Disability Act:</u></b>	
1. Does this office meet ADA accessibility requirements?	Yes      No
<b><u>Physical Accessibility:</u></b>	
2. Facility entry is handicapped accessible?	Yes      No
3. Bathrooms are handicapped accessible?	Yes      No
4. Exam tables are handicapped accessible?	Yes      No