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 _____**
Fri _____ to _____	**Sat _____ to _____**
Sun _____ to _____	

Site Assessment

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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 ☐

HealthCare Partners, IPA
HealthCare Partners, MSO

HCP Provider
Conflict of Interest Disclosure Statement

I,_____, hereby declare that:
Provider Name

☐ 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**.

Signed: _____ Date: _____

Print Name: _____

Title: _____

501 Franklin Avenue, Suite 300
Garden City, NY 11530
F: (516) 294 – 9470
www.HealthCarePartnersNY.com

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

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.

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

Social security number

or

Employer identification number

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.

Sign Here **Signature of U.S. person ▶** **Date ▶**

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,