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:

Site Assessment Tool - Complete 1 per location

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#:		**Group NPI:**
Street Address:		
City:	**State:**	**Zip:**
Phone#:		**Fax#:**
EMR System Name:		

Office Hours **Primary Care Physicians ONLY** **(Internal Medicine, Family Medicine, Family Practice, Pediatrics)**	
A minimum of 16 hours per week is required at each location, with a maximum of 48 total hours across all locations. Hours cannot overlap between locations.	
Mon ____________ **to** ____________	**Tues** ____________ **to** ____________
Wed ____________ **to** ____________	**Thurs** ____________ **to** ____________
Fri ____________ **to** ____________	**Sat** ____________ **to** ____________
Sun ____________ **to** ____________	

Please complete a separate page for each additional office location where the provider practices.

Additional Location

Practice Name:		
Tax ID#:		Group NPI:
Street Address:		
City:	State:	Zip:
Phone#:		Fax#:
EMR System Name:		

Office Hours

Primary Care Physicians ONLY
(Internal Medicine, Family Medicine, Family Practice, Pediatrics)

A minimum of 16 hours per week is required at each location, with a maximum of 48 total hours across all locations. Hours cannot overlap between locations.

Mon ____________ **to** ____________	**Tues** ____________ **to** ____________
Wed ____________ **to** ____________	**Thurs** ____________ **to** ____________
Fri ____________ **to** ____________	**Sat** ____________ **to** ____________
Sun ____________ **to** ____________	

SITE ASSESSMENT TOOL

Please complete a form for <u>each</u> 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.

<u>AMERICAN DISABILITY ACT</u>

1.	Does this office meet ADA accessibility requirements?	Yes	No

<u>PHYSICAL ACCESSIBILITY</u>

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

<u>PHYSICAL APPEARANCE</u>

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

<u>ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS</u>

11.	Adequate seating in waiting room (3 chairs per physician)?	Yes	No
12.	Exam room equipped with adequate space/privacy?	Yes	No

<u>ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING</u>

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

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 sheets of 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 www.HealthCarePartnersNY.com, and I agree to disclose any actual, potential or perceived conflict of interest during the credentialing and recredentialing period and at any other time a Conflict of Interest may arise.

Signed: ______________________________ Date: ______________________________

Print Name: ______________________________

Title: ______________________________