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

<table>
<tr><th colspan="2"><u>Provider Information</u></th></tr>
<tr><td>Provider Last Name:</td><td>Provider First Name:</td></tr>
<tr><td>Title/Degree:</td><td>CAQH#:</td></tr>
<tr><th colspan="2"><u>Covering Practitioner</u>
You must have coverage arrangements to assure that services are available on a 24/7 basis.</th></tr>
<tr><td colspan="2">Name of covering provider:</td></tr>
<tr><td colspan="2">Provider's Specialty:</td></tr>
<tr><td colspan="2">Covering Provider Address:</td></tr>
<tr><td colspan="2">Phone#:</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><th colspan="2"><u>Affiliations</u></th></tr>
<tr><td>Does provider belong to another IPA?
☐ Yes ☐ No</td><td>If yes, please indicate IPA:</td></tr>
<tr><td>Does provider belong to an ACO?
☐ Yes ☐ No</td><td>If yes, please indicate ACO:</td></tr>
</table>

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: ______________________________

Form **W-9** (Rev. March 2024) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . ____

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ____

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ____

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) ____

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* 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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

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

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they