Provider Credentialing Form

EmblemHealth®

Tell us about your practice and how you would like to participate with our plan(s).

Provider Last Name:	**Provider First Name:**	**Gender:**

Title (check appropriate boxes): ☐ MD ☐ DO ☐ DC ☐ PA ☐ NP/APRN ☐ DPM ☐ Other:

NPI:	**CAQH ID #:**

Who should we contact if we have questions about this application?

Credentialing Contact:	**Credentialing Email:**	**Credentialing Phone:**

Company Applying To

Please see our Provider Participation by Line of Business Map to see the geographic areas our networks cover.

EmblemHealth*

☐ EmblemHealth Plan, Inc. (formerly GHI) Submit signed contract documents with application.
Download the **EmblemHealth Plan, Inc. Participating Practitioner Agreement**.

☐ Health Insurance Company of Greater New York** and EmblemHealth Insurance Company*** Submit signed contract documents with application.

*If you are applying for EmblemHealth and do not have a group contract, you must attach the applicable signature page for each company selected above.

**If you are eligible for participation in any of these networks, a contract will be sent to you.

***Plans are only offered in the following New York counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Orange, Otsego, Putnam, Queens, Ulster, Westchester, Warren, Washington, Schoharie, Schenectady, Richmond, Rockland, Rensselaer, Saratoga, Suffolk, Sullivan, Nassau, and New York.

Practitioner Type: (select one)	**Are you accepting new patients?**
☐ Primary Care Provider (PCP) - Number of working hours per week: _____ ☐ Dual PCP/Specialist - Number of working hours per week: _____ ☐ Specialist	☐ Yes ☐ No **Board certified?** ☐ Yes ☐ No ☐ N/A If yes, please list board(s):

Specialty to appear in the directory:

Advanced Practice Clinicians and Allied Health Professionals Only

APRN/NP
Submit nursing certification with application.

APRN/NP/PA/Midwife
Indicate name and National Provider Identifier (NPI) of collaborating physician or submit a collaborative practice agreement with application.

Collaborating Physician Name:	**Collaborating Physician NPI:**

Massachusetts PA PCPs
Submit your PA certification and collaborative practice agreement with your application.

Joining a group practice? ☐ Yes ☐ No	**Group Name:**

Do you practice exclusively in an inpatient setting (i.e., patients cannot call and make an appointment to see you)? ☐ Yes ☐ No

If yes, please list hospital:

PRINT RESET

Tell us about your practice locations.

PRIMARY LOCATION

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

Are you applying to participate at all locations on your CAQH Application?

☐ Yes (Skip the **Additional Offices** section.)
☐ No (Complete the following information for each additional office you would like us to consider.)

ADDITIONAL OFFICE #1

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

ADDITIONAL OFFICE #2

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

ADDITIONAL OFFICE #3

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

ADDITIONAL OFFICE #4

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

ADDITIONAL OFFICE #5

Name of Practice or Facility:

Address 1:

Address 2:

City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

ADDITIONAL OFFICE #6		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	**State:**	**ZIP:**

Can patients make appointments with you at this address? ☐ Yes ☐ No

Enter Taxpayer Identification Number (TIN): _____
Submit W-9 with application. **Download W-9 Form (www.irs.gov/forms-instructions)**
Note: TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	**Email address for plan notifications:**

Place of Service:

- ☐ In office.
- ☐ Inpatient hospital (not shown in our directories).
- ☐ Outpatient hospital (not shown in our directories).
- ☐ Ambulatory surgical center (not shown in our directories).
- ☐ Home-based services (not shown in our directories).
- ☐ Skilled nursing facility (not shown in our directories).
- ☐ Homeless shelter (not shown in our directories).
- ☐ Domestic violence shelter (not shown in our directories).
- ☐ Veteran's administration facility (not shown in our directories).
- ☐ Virtual (not shown in our directories).
- ☐ School-based (not shown in our directories).
- ☐ Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location? ☐ Yes ☐ No

Submit your application and supporting documents.

After you complete this form, save it as a PDF and submit it by email to the appropriate email address below. You must include the W-9s for each TIN referenced above.

EmblemHealth: Also email your completed contract agreement(s) if applicable to: **credentialingnyc@emblemhealth.com.**

What happens next?

Applicants have the right to review the information submitted in support of their application and to correct erroneous information. EmblemHealth will notify the applicant of any information obtained during the credentialing process that varies substantially from the information submitted.

Please note: The email addresses above are for the submission of new applications only. Our credentialing team will reach out to you if additional information is needed. We recommend waiting at least 60 days before checking the status of your application by calling our Provider Customer Services team:

EmblemHealth: **866-447-9717**

If you have an account for our secure provider portal, **emblemhealth.com** or **connecticare.com**, you can check your practice profile to see if your participation has changed.

CAQH requires providers to validate their information every 120 days. Recredentialing occurs every three years and relies on the CAQH application. Please keep your information current and ensure EmblemHealth remains an authorized plan.