EmblemHealth®

PROVIDER CREDENTIALING CHECKLIST

To begin the application process, please complete the following: (Please print legibly)

Provider Last Name:	**Provider First Name:**		**NPI #**
Credentialing Contact: ☐ Yes ☐ No	**Credentialing Email:**	**Credentialing Phone:**	
Joining a group practice?: ☐ Yes ☐ No	**Group Name:**	**Tax ID:**	
CAQH ID #	**State License #**	**Are you enrolled in Medicare?** ☐ Yes ☐ No	

Brands: GHI PPO ___________ HIP* __________

*HIP 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

Physician Type: (select one) ☐ PCP ☐ SPECIALIST ☐ DUAL (PCP and SPECIALIST) Dual providers must meet PCP appointment guidelines.

REQUESTED SPECIALTY to appear in EmblemHealth Directory:

RECRUITED SERVICE ADRESSES

To ensure appropriate listing in our provider directories, please confirm the following detail on each service location from your CAQH application:

ADDRESSES RECRUITED:

☐ All on CAQH under TIN above (complete section 1 only) ☐ Limited to the following below: (complete section 1 and 2)
☐ If more than 6 locations: (complete section 1 and attach list of all service locations on letterhead)

SECTION 1: PRIMARY LOCATION

1. Address:	**Service Address:** ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	**Are there any age restrictions to your practice?** ☐ Yes ☐ No

Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age _________________ indicate maximum age _________________

☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)

SECTION 2: ADDITIONAL OFFICES

2. Address:	**Service Address:** ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	**Are there any age restrictions to your practice?** ☐ Yes ☐ No
If different TIN, W-9 attached? ☐ Yes ☐ No	**TIN:**

Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age _________________ indicate maximum age _________________

☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)

3. Address:	**Service Address:** ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	**Are there any age restrictions to your practice?** ☐ Yes ☐ No
If different TIN, W-9 attached? ☐ Yes ☐ No	**TIN:**

Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age _________________ indicate maximum age _________________

☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)

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PROVIDER CREDENTIALING CHECKLIST

(Continued)

4. Address:	Service Address: ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	Are there any age restrictions to your practice? ☐ Yes ☐ No
If different TIN, W-9 attached? ☐ Yes ☐ No	TIN:
Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age __________ indicate maximum age __________	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	

5. Address:	Service Address: ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	Are there any age restrictions to your practice? ☐ Yes ☐ No
If different TIN, W-9 attached? ☐ Yes ☐ No	TIN:
Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age __________ indicate maximum age __________	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	

6. Address:	Service Address: ☐ Yes ☐ No
	Can patients make appointments with you at this address? ☐ Yes ☐ No
	Should location print in the directory? ☐ Yes ☐ No
Appointment Phone #:	Are there any age restrictions to your practice? ☐ Yes ☐ No
If different TIN, W-9 attached? ☐ Yes ☐ No	TIN:
Ages: ☐ 0 – 20yrs ☐ 21yrs and over OR ☐ indicate minimum age __________ indicate maximum age __________	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
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PLEASE ATTACH THESE ITEMS TO APPLICATION:

- ☐ W-9 (all W-9s referenced in Recruited Service Addresses section, must be signed and dated)
- ☐ Participating hospital privileges or coverage arrangements with participating provider:
- ☐ Collaborative agreement (If applicable)
  - Nurse Practitioner Services
  - Physician Assistant
  - Midwifery Services
- ☐ Roster or listing on letterhead confirming group provider status (Group Agreement Only)
- ☐ ADA Attestation completed for each HMO service location submitted

INTERNAL STAFF ONLY (COMPLETE SECTION BELOW):	
Submitter initials:	CONTRACT AFFILIATION: Indicate networks to which provider is applying: ☐ HIP ☐ GHI
Group Agreement on File ☐ Yes ☐ No If yes, indicate group name:	CHC/D&TC/FQHC Agreement on File ☐ Yes ☐ No If yes, indicate entity name:
Indicate networks covered in master or group agreement: ☐ GHI ☐ HIP ☐ Legacy GHI HMO Select Inc.	