



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

Provider Last Name:	Provider First Name:	NPI #
Credentialing Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	Credentialing Email:	Credentialing Phone:
Joining a group practice?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Group Name:	Tax ID:
CAQH ID #	State License #	Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> PCP <input type="checkbox"/> SPECIALIST <input type="checkbox"/> DUAL (PCP and SPECIALIST) Dual providers must meet PCP appointment guidelines.		
REQUESTED SPECIALTY to appear in EmblemHealth Directory:		

RECRUITED SERVICE ADDRESSES

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: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should location print in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ages: <input type="checkbox"/> 0 – 20yrs <input type="checkbox"/> 21yrs and over OR <input type="checkbox"/> indicate minimum age _____ indicate maximum age _____	
<input type="checkbox"/> (In-Office) <input type="checkbox"/> (Inpatient hospital) <input type="checkbox"/> (Outpatient hospital) <input type="checkbox"/> (Ambulatory surgical center)	

SECTION 2: ADDITIONAL OFFICES	
2. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should location print in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
If different TIN, W-9 attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	TIN:
Ages: <input type="checkbox"/> 0 – 20yrs <input type="checkbox"/> 21yrs and over OR <input type="checkbox"/> indicate minimum age _____ indicate maximum age _____	
<input type="checkbox"/> (In-Office) <input type="checkbox"/> (Inpatient hospital) <input type="checkbox"/> (Outpatient hospital) <input type="checkbox"/> (Ambulatory surgical center)	

3. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should location print in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
If different TIN, W-9 attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	TIN:
Ages: <input type="checkbox"/> 0 – 20yrs <input type="checkbox"/> 21yrs and over OR <input type="checkbox"/> indicate minimum age _____ indicate maximum age _____	
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PROVIDER CREDENTIALING CHECKLIST

(Continued)

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

6. Address:	Service Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Should location print in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Phone #:	Are there any age restrictions to your practice? <input type="checkbox"/> Yes <input type="checkbox"/> No
If different TIN, W-9 attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	TIN:
Ages: <input type="checkbox"/> 0 – 20yrs <input type="checkbox"/> 21yrs and over OR <input type="checkbox"/> indicate minimum age _____ indicate maximum age _____	
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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: <input type="checkbox"/> HIP <input type="checkbox"/> GHI
Group Agreement on File <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate group name:	CHC/D&TC/FQHC Agreement on File <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate entity name:
Indicate networks covered in master or group agreement: <input type="checkbox"/> GHI <input type="checkbox"/> HIP <input type="checkbox"/> Legacy GHI HMO Select Inc.	