**HealthCare Partners, IPA**
**HealthCare Partners, Management Services Organization**
**501** Franklin Avenue, Suite 300, Garden City, New York 11530 (516) 746-2200 Fax (516) 294-9470

# APPLICATION REQUEST FORM

Date of Request:_____

**Type of Entity**: ☐ **PCP**_____ ☐ **Specialist:**_____

☐ **Medical Group** ☐ **Ancillary**:_____

Name: _____

Address: _____

Contact Name/Title: _____

Telephone: _____ Fax Number: _____

Email Address: _____

Additional Locations: YES/NO

**Reason for interest in HCP's Network**: _____

_____

**Contracted with Affiliates**: ☐ Emblem ☐ LHA ☐ Empire

SPECIALTY:_____

_____

COMMON CODES BILLED UNDER SPECIALITY:

_____

Physician: Board Certified Yes/No

What Hospital(s) are you primarily affiliated with? _____

_____

COMMENTS:_____

_____

IF YOU HAVE NOT RECEIVED A RESPONSE AFTER 60 DAYS, YOU MAY CALL OUR PROVIDER SERVICES DEPARTMENT AT 800-877-7587 OPTION #4

* All requests are reviewed on an individual basis; this request does not guarantee a direct contract with HCP