HealthCare Partners, IPA
HealthCare Partners, Management Services Organization
501 Franklin Avenue, Suite 300, Garden City, New York 11530 (516) 746-2200 Fax (516) 515 - 8843

RE-CREDENTIALING with HEALTHCARE PARTNERS, IPA

Provider's Name: ______________________________

Provider's CAQH#: ____________________________

IMPORTANT: Failure to respond to our request for the re-credentialing documentation will result in the termination of your participation from all HCP delegated networks at the end of your re-credentialing cycle.

********Please submit the following documents********

- **Application** (either one of the two listed below):
  - **CAQH** - if you are registered and "**current**" with CAQH, please ***provide your CAQH# on the line above and sign the enclosed CAQH attestation page*** *(used to verify provider's current hospital privileges); otherwise complete the HCP application.*
  - **HealthCare Partners (HCP) application** – *please see attached instruction sheet on how to download our application.*

- Copy of your current **New York State License**
- Copy of your current **DEA Certificate** (if applicable)
- Copy of your current **Malpractice Insurance Certificate**

- **Active Office Location form** – complete the attached form listing all your active office locations where you see HCP members

- **Site Assessment Tool** – complete the attached form for each active location

- **Covering Practitioner form** – complete the attached form

FAX Completed Documents to: 516-515-8843
-or-
Mail To:
HEALTHCARE PARTNERS, IPA
Credentialing Department
501 FRANKLIN AVENUE, Suite 300
GARDEN CITY, NY 11530

Call the Credentialing Department at 516-746-2200 with any questions you may have before sending in the Re-credentialing package.

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature* Name (print)*

DATE SIGNED*

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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Provider's Name: ______________________________
(please print)

Active Office Locations with HealthCare Partners, IPA

Primary Office Address: ______________________________
____

Office Address: ______________________________
____

Office Address: ______________________________
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Office Address: ______________________________
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Office Address: ______________________________
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Office Address: ______________________________
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Office Address: ______________________________
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Office Address: ______________________________
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Office Address: ______________________________
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*Please be sure **all** locations listed above are included on your CAQH or HCP application. For additional locations, please photocopy this form.*

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SITE ASSESSMENT TOOL

Please complete a form for each ACTIVE office location

(Be sure to make additional copies, one for each location)

Practice Name: ______________________________

Street: ______________________________

City/State/Zip Code: ______________________________

Office Phone#: ______________ Office Fax#: ______________

Please list the hours the "Provider" is at this location:

M ___-___ **T** ___-___ **W** ___-___ **TH** ___-___ **F**___-___ **SAT** ___-___ **SUN** ___-___

NOTE: For any **NO** response, please provide an explanation on a separate sheet of paper.

AMERICAN DISABILITY ACT (view at **ada.gov/racheck.pdf**)

1. Does this office meet ADA accessibility requirements? □ **YES** □ **NO**

PHYSICAL ACCESSIBILITY

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**

PHYSICAL APPEARANCE

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 is displayed? □ **YES** □ **NO**

ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS

11. Adequate seating in waiting room (3 chairs per physician)? □ **YES** □ **NO**
12. Exam room equipped with adequate space/privacy? □ **YES** □ **NO**

ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING

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**

SCORE: ______

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COVERING PRACTITIONER FORM

Dear Practitioner:

In order to participate in the HealthCare Partners, IPA Network you must have coverage arrangements to assure that services are available on a twenty-four-hour-a-day, seven-days-a-week basis. Covering providers should be the same or similar specialty and be participating with HealthCare Partners or an affiliated health plan.

STEP 1: Please complete the next four lines with "Your" information:

Print Name: ______________________________

Signature: ______________________________

Specialty: ______________________________

Date: ______________________________

STEP 2: Please complete the grid below with the information of the provider(s) who will cover for you:

Name	*Specialty*	*Address*	*Phone #*

Please submit this form with your credentialing/recredentialing application

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Instructions on How to Print a HCP Application

***ONLY* complete the HCP application if you are *NOT* registered and current on CAQH.**

Please follow these instructions in order to download/print the HCP application from our website:

- *Log onto: www.hcpipa.com*
- *Click: Provider Services*
- *Click: Credentialing*
- *Click HCP Re-Credentialing Application*

Note: you are still required to complete the documents included in the recredentialing package you received.