Provider Credentialing Form

EmblemHealth

Thank you for your interest in becoming an EmblemHealth participating provider. EmblemHealth and the Council for Affordable Quality Healthcare (CAQH) have joined forces to provide an online credentialing application database. To update your application or learn more about CAQH Proview, visit **www.caqh.org**. Add EmblemHealth to your list of "Authorized Health Plans" or choose the "Global Access" option and update your application to reflect current information.

Note: If you are a behavioral health, musculoskeletal services (physical therapy, occupational therapy, or chiropractic), dental, or vision services provider, please refer to EmblemHealth's Join Our Networks page (**https://www.emblemhealth.com/providers/resources/join-our-network)** before using this form. You may be required to apply through one of our partners for participation with EmblemHealth.

This form and a W-9 must be completed to begin the credentialing process. Please complete and submit by email:

- For applicants in New York City's five boroughs, Nassau and Suffolk counties, New Jersey, and Connecticut, please send your completed application and agreement(s) to: **CredentialingNYC@emblemhealth.com**.
- For applicants in all other counties in New York State and other states, please send your completed application and agreement(s) to: **CredentialingSYR@emblemhealth.com**.

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 45 days before checking on the status of your application. To check status, call our Provider Services Line at **877-842-3625**.

To be listed in the directory for a specific location, the provider must actively be seeing patients at the location on a regular and consistent basis but, in no event, less than once per week. A "regular and consistent basis" does not include covering physicians who are in the office occasionally.

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

Provider Last Name:	**Provider First Name:**		**Gender:**
SSN#:	**NPI:**	**CAQH ID #:**	**State/State License #:**
Are you enrolled in Medicare? ☐ Yes ☐ No		**Federal DEA #:**	
Credentialing Contact:	**Credentialing Email:**		**Credentialing Phone:**
Joining a group practice? ☐ Yes ☐ No	**Group Name:**		**Tax ID:**
Do you have privileges at an Ambulatory Surgery Center? ☐ **Yes** ☐ **No. If yes, please indicate the name and address of the facility:**			
Adding Tax ID:		**Terminating Tax ID:**	
State: ☐ NY ☐ NJ ☐ CT ☐ FL ☐ Other		**Line of Business:** ☐ Commercial/CHP ☐ Medicare ☐ Medicaid	
Practitioner Type: (select one) ☐ PCP* ☐ Specialist ☐ Allied Health Professional* APRN/NP must attach your Nursing Certification and Collaborative Agreement		**PCP only:** Number of working hours per week: _____ Are you accepting new patients? ☐ Yes ☐ No	
**Midlevel providers only: Provide the name of your supervisor/collaborating physician: _____			
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:			
Does your office provide online services, i.e., prescription refills, appointments, clinical questions, etc.? ☐ Yes ☐ No			
SPECIALTY to appear in the Directory:		Board certified? ☐ Yes ☐ No ☐ N/A If yes, please list board:	

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 sections 1 and 2)
☐ If more than 6 locations: (complete section 1 and attach list of all service locations on letterhead)

RESET PRINT SUBMIT

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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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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 – 20 yrs ☐ 21 yrs and over OR ☐ Indicate minimum age _____ indicate maximum age _____	
☐ (In-Office) ☐ (Inpatient hospital) ☐ (Outpatient hospital) ☐ (Ambulatory surgical center)	
Do you see patients on a regular and consistent basis, at least one day a week, in the above location? ☐ Yes ☐ No	

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Payment address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing address same as: ☐ Practice ☐ Mailing ☐ Other Street Address:		
City:	**State:**	**ZIP:**
Mailing Office Phone #:	**Mailing Office Fax #:**	

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 Services
- Midwifery Services

☐ Participating hospital privileges or coverage arrangements with participating provider

☐ ADA Attestation completed for each HMO service location submitted

This form and a W-9 must be completed to begin the credentialing process.

EmblemHealth makes its Administrative Guidelines, including but not limited to, the EmblemHealth Provider Manual (which includes the credentialing criteria and your rights during the process), Medical Policies, Clinical Practice Guidelines, Appointment Availability & After Hours Access Standards, Referral, Preauthorization requirements, policy updates, and other participation requirements and useful tools, available on **emblemhealth.com/providers**. I understand that in applying for participation with EmblemHealth and its companies, I am agreeing to review and comply with these terms. I am responsible for checking **emblemhealth.com/providers** for updates and for providing a valid email address to EmblemHealth so updates may be sent to me.

☐ By checking this item, I am acknowledging receipt of the EmblemHealth Provider Manual, which is available online. **If I cannot access the manual online, I acknowledge that I have called EmblemHealth's Provider Customer Service at 866-447-9717 to request a copy of the manual.**

☐ I hereby attest, the provider(s) covered by this application have completed the current years' EmblemHealth Special Needs Plan (SNP) Model of Care (MOC) training link located at **https://www.emblemHealth.com/providers/resources/news/dsnp-provider-training**, which is required by the Centers for Medicare & Medicaid Services (CMS). I declare the above statement is true and accurate to the best of my knowledge. Additionally, this will confirm I hold the authority to make this attestation on behalf of all providers covered by this application.		
Required attestation information completed by (Signature):		
First Name (Please print):	Last Name (Please print):	Date Signed:
Relationship to above-named provider (e.g., self, office manager, nurse, other):		

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.