Provider Data Collection Form

CAQH ID:	Provider Name:	
Individual NPI:	Hospital Affiliation:	
Group NPI:	PROMISe ID:	TIN:
Primary Practice Name:		
Primary Practice Address:		
Birth Date:	Practice Phone #	
Applying as a... (circle one) PCP Specialist PCP/Specialist* Allied Health		
Covering Colleague: Applying as a CRNP/PA-C, please list collaborative or supervising physician name & submit collaborative agreement/supervising registration forms.		
Ethnicity:		
Credentialing Contact name & email:		
License #	Board Certified: □ Yes □ No	
Practicing Specialty for Directory:		
Home Visits Performed? □ Yes □ No		

Attestation Statement and Authorization to Release Information

I certify that all of the information that I have submitted in connection with the application is true, accurate and complete. I understand that Health Partners Plans will rely on this information to evaluate my participation in the program(s) provided through Health Partners Plans.

I understand and agree that I am to adhere to and abide by the terms and conditions of this program(s) and any and all Agreements I have or will in the future enter into with Health Partners Plans.

I understand that any material misstatement or omission of fact on the application is grounds for action by Health Partners Plans, including but not limited to summary dismissal from Health Partners Plans as provided in the Provider Agreement.

I attest to having in the amounts required by the State of Pennsylvania current, valid malpractice insurance coverage and all other applicable professional insurances.

I agree to adhere to the code of ethics of the AMA, AOA or the __________________ (appropriate professional organization of specialty or scope of practice).

I authorize Health Partners Plans and/or its designated credentialing agent to consult with members of the medical staff, affiliate hospitals, professional liability carriers, and healthcare facilities with which I have been associated. In addition, this authorization includes consultation with other healthcare professionals who may have information bearing on my competency, character, physical health status, emotional health status, and ethical aspects of my professional practice.

I authorize release of such information to Health Partners Plans and/or its designated credentialing agent upon request. I agree a facsimile or photocopy of my signature will serve the same as the original.

I attest that I have clinical admitting privileges at the Health Partners Plans participating hospital noted on my CAQH or PA Standard application.
I agree to release all Medical Assistance records pertaining to sanctions and/or settlements to HPP and the Pennsylvania Department of Human Services.
I agree to attend at least one HPP sponsored provider education training session annually.

____
Signature of Applicant (DO NOT USE STAMP)

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Printed Name of Applicant

Date______________________________

Submit Form to: credentialing@hpplans.com

For Health Partners Plans Use Only

__________ Provider is linked to group agreement?

_________________________ Master Contract ID #

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***If you are serving as both a PCP and a Specialist at the same practice location, you must have separate group NPIs for each provider type.**