UNIVERSITY PHYSICIANS
BROOKLYN, INC.

PROVIDER ENROLLMENT SERVICES
PAYOR REQUIRED FORMS

_____
Provider Name

Physicians are required to sign the following forms as part of the enrollment process:

- ☐ Enrollment Provider Database Form
- ☐ Provider Practice Location Information Form
- ☐ CAQH Attestation (if needed)
- ☐ Blue Cross Blue Shield Application Signature Pages
- ☐ Blue Cross Blue Shield Practitioner Form
- ☐ Healthcare Partners Covering Physician Form
- ☐ Healthcare Partners ADA Form
- ☐ Healthcare Partners Contract Signature Form
- ☐ Healthcare Partners Credentialing Application Form
- ☐ Magnacare Provider Participation Agreement
- ☐ Magnacare Federal Tax Identification Numbers Signature Form
- ☐ HIP Participating Practitioner Agreement
- ☐ HIP Network Services IPA Participating Practitioner Agreement
- ☐ HIP Certification Regarding Lobbying
- ☐ HIP Special Provisions Related to Medicaid and Family Health Plus Members
- ☐ GHI PPO Participating Provider Agreement
- ☐ GHI HMO Participating Provider Agreement
- ☐ ADA Attestation Form

Additional forms will be generated from Provider Enrollment:

Medicare Certification Statement for Provider and Medicare Re-assignment From
Medicaid Provider Enrollment and Medicaid Electronic Funds Transfer Form

Thank you,

Marilyn Vientos Sotiriadis
Chief Operating Officer

X _____ X _____
Person Completing Check List Initials/Date

SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

UNIVERSITY PHYSICIANS BROOKLYN, INC.

PROVIDER ENROLLMENT SERVICES
PRACTICE LOCATION INFORMATION

Provider First Name: _____ Last Name: _____

Primary Practice Address: _____ UPB ☐ UHB ☐ BOTH ☐

City/State/Zip: _____

Appointment Phone Number: (_____)_____

Office Fax Number: (_____)_____ Contact Person: _____

Office Hours:

Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

****

Secondary Practice Address: _____ UPB ☐ UHB ☐ BOTH ☐

City/State/Zip: _____

Appointment Phone Number: (_____)_____

Office Fax Number: (_____)_____ Contact Person: _____

Office Hours:

Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

****

SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

UNIVERSITY PHYSICIANS BROOKLYN, INC.

Additional Practice Address: _____ UPB ☐ UHB ☐ BOTH ☐

City/State/Zip: _____

Appointment Phone Number: (_____)_____

Office Fax Number: (_____)_____ Contact Person: _____

Office Hours:

Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

****

Additional Practice Address: _____ UPB ☐ UHB ☐ BOTH ☐

City/State/Zip: _____

Appointment Phone Number: (_____)_____

Office Fax Number: (_____)_____ Contact Person: _____

Office Hours:

Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

C90H

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*

EMPIRE BLUECROSS BLUESHIELD
PRACTITIONER RELEASE FORM

PRACTITIONER INFORMATION		
Provider Number:	CAQH Number:	NPI Number:
Last Name:	First Name:	M.I.:
Date of Birth:	SSN:	TIN:
Sex: ☐ Male ☐ Female	Part of a Group? ☐ Yes ☐ No	
Languages Spoken:		
Primary Office Address:		
City:	State:	ZIP Code:
Telephone #:	Fax #:	Contact Name:

OFFICE HOURS
Hours of Availability to see Patients in Primary Office

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I HAVE NO OFFICE HOURS AND RENDER SERVICES ONLY WITHIN AN INPATIENT SETTING (HOSPITALIST) ☐

PAR HOSPITAL AFFILIATIONS
List all – Use Separate Sheet if Necessary

1.
2.

SPECIALTY

APPLYING AS: *(PLEASE CHECK)* PRIMARY CARE PROVIDE / OB/GYN CP ☐ REFERRAL SPECIALIST ☐ BOTH ☐

Specialty:	Board Eligible?	☐ Yes	☐ No	Date:
	Board Certified?	☐ Yes	☐ No	Date:
Sub-Specialty:	Board Eligible?	☐ Yes	☐ No	Date:
	Board Certified?	☐ Yes	☐ No	Date:

PAR BACKUPS
List all – Use Separate Sheet if Necessary

Name	Provider ID	Address	Phone
1.			
2.			
3.			

I hereby certify that the all information indicated herein is true, accurate and complete. Furthermore I understand that the knowing submission of any incorrect information may result in the possible disqualification of my application, termination of my agreement with Empire BlueCross BlueShield and reporting to any applicable State, Federal or Regulatory agency.

Provider Signature:	Date:
Empire Use Only	
Provider Network Management Consultant Name: Terry Marinas	Date Empire Received

Please Return this form along with the Contract(s) to:

Empire BlueCross BlueShield,
Attn: Physician Contracting & Relations, P.O. Box 1407, Church Street Station,
New York, NY 10008-1407

represent any Physician outside of his or her Physician Group, if applicable. Judgment upon the award rendered by the arbitrator may be entered and enforced in any court of competent jurisdiction. In the event the dispute is required by law to be resolved by a state or federal authority, Empire and Physician agree to be bound by the findings of such state or federal authority.

IN WITNESS HEREOF, the parties have caused their duly authorized representatives to execute this Agreement.

Empire HealthChoice Assurance, Inc.
Empire HealthChoice HMO, Inc.

_____
Signature

_____
Print Name and Title Date

Physician

_____
Signature

_____
Print Name Date

Check All That Apply

- ☐ Primary Care Physician*
- ☐ Referral Specialist

*Only a Family Physician, Internist or Pediatrician may designate him or herself as a Primary Care Physician.

Primary Office Address

_____

_____

Telephone Number _____

Tax ID Number _____
(Please photocopy for your records.)

HealthCare Partners, IPA
HealthCare Partners, Management Services Organization
501 Franklin Avenue, Suite 300, Garden City, New York 11530 (516) 746-2200 Fax (516) 746-6433

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.

Please provide the following information on your covering practitioners:

Name	Specialty	Address	Phone #

Please submit this form with your credentialing/recredentialing application

Print Name: _____

Signature: _____

Specialty: _____

Date: _____

HealthCare Partners
The American with Disabilities Act (ADA) Checklist

Provider Name (print): _____ **Date:** _____

Provider Signature: _____

Provider Address: _____

Specialty: _____

ADA is a federal statute that requires public accommodations to provide goods and services to people with disabilities on an equal basis as that provided to the general public. Structural barriers to access should be removed only when the correction is readily achievable, which is defined by the law as easily accomplished and able to be carried out without much difficulty or expense. HCP is required to report aggregate statistics on the percentage of providers by geographic area and specialty that practice in ADA compliant facilities. Toward that end, we request that you respond to the following questions. **Please note that the information provided here will in no way affect your affiliation with HealthCare Partners.**

Please enter your overall assessment based on the answers provided in the ADA Checklist. If an ADA Objective in either the* Access to Facility from the Exterior *or* Access to Interior Spaces *sections is answered* NO, *then the office is not considered accessible from points of entrance to exam rooms. If an objective is italicized it should not be considered as part of your summary assessment. If an ADA Objective in the* Access to Public Lavatory *section is not italicized and is answered* NO, *then the public lavatory is not considered accessible.

Does the office have at least one wheelchair-accessible path from an entrance to an exam room? YES____ NO____

Is the public lavatory wheelchair-accessible? YES____ NO____

Is the office equipped with at least one exam table with height-lowering capability? YES____ NO____

ACCESS TO FACILITY FROM THE EXTERIOR

ADA OBJECTIVE

	Yes	No
1. Is there a path of travel from the disability accessible parking space to the facility entrance that does not require the use of stairs?	_____	_____
2. Is the path of travel stable, firm and slip resistant?	_____	_____
3. Except for curb cuts, is the path at least 36 inches wide?	_____	_____
4. Is there a method for persons using wheelchairs or that require other assistance with mobility to enter as freely as everyone else?	_____	_____
4a. Is that route of travel safe and accessible for everyone, including people with disabilities?	_____	_____

Provider Name (print): _____ Date: _____

ACCESS TO FACILITY FROM THE EXTERIOR (continued)

ADA OBJECTIVE

	Yes	No
5. Are there an adequate number of parking spaces provided (8 feet wide for a car and 5 foot access aisle)?	_____	_____

Total Spaces	Accessible Spaces
1-25	1
26-50	2
51-75	3
76-100	4

6. Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meets the following standards: _____ _____

- 32 inches clear opening.
- 18 inches of clear wall space on the pull side of the door, next to the handle.
- The threshold edge is no greater than ¼ inch high or if beveled, no greater than ¾ inches high.
- The door handle is no higher than 48 inches high and can be operated with a closed fist.

7. Are there ramps to permit wheelchair access? _____ _____
If yes, complete the following 4 questions:

7a. Are the slopes of the ramp accessible for wheelchair access? _____ _____

7b. Are the railings sturdy and high enough for wheelchair access? _____ _____

7c. Is the width between railings wide enough to accommodate a wheelchair? _____ _____

7d. Are the ramps nonslip and free from any obstruction (cracks)? _____ _____

8. If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance? _____ _____

9. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? _____ _____

10. Can the accessible entrance be used independently and without assistance? _____ _____

11. Are doormats ½ inch high or less with beveled or secured edges? _____ _____

Provider Name (print): _____ **Date:** _____

ACCESS TO INTERIOR SPACES

ADA OBJECTIVE

	Yes	No
12. The layout of the interior of the building allows people with disabilities to obtain materials and services without assistance.	_____	_____
13. The interior doors comply with the criteria set forth above regarding the exterior door.	_____	_____
14. The accessible routes to all public spaces in the facility are 31 inches wide.	_____	_____
15. There is a 5 foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered.	_____	_____
16. All buttons or other controls in the hallway are no higher than 42 inches.	_____	_____
17. Elevators in the facility meet the following standards:		
• There is a raised *and Braille sign* on both door jambs on every floor;	_____	_____
• The call buttons in the hallway are not higher than 42 inches; and	_____	_____
• The controls inside the cab have raised and *Braille lettering.*	_____	_____
18. *The office is equipped with TTY capability.*	_____	_____

ACCESS TO PUBLIC LAVATORY

ADA OBJECTIVE

	Yes	No
20. With respect to the public restroom, the accessible route, the exterior door and the interior stall doors comply with standards set forth above for exterior doors.	_____	_____
21. There is at least one wheelchair accessible stall in the public restroom that has an area of at least 5 feet by 5 feet, clear of the door swing; OR there is at least one stall that is less accessible but that provides greater access than a typical stall (either 36 by 69 inches, or 48 by 69 inches).	_____	_____

Provider Name (print): _____ Date: _____

ACCESS TO PUBLIC LAVATORY (continued)

ADA OBJECTIVE

	Yes	No
22. In the accessible stall of the public rest room there are grab bars behind and on the side wall nearest the toilet.	_____	_____
23. There is one lavatory in the public restroom that meets the following standards:	_____	_____
• 30 inches wide by 48 inches; deep bar space in front. (A maximum of 19 inches of the required depth may be under the lavatory.)	_____	_____
• The lavatory rim is no higher than 34 inches.	_____	_____
• There is at least 29 inches from the floor to the bottom of the lavatory apron.	_____	_____
• *The faucet can be operated with a closed fist.*	_____	_____
• *The soap dispenser and hand dryers are within reach and usable with one closed fist.*	_____	_____
• *The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower.*	_____	_____

Please submit completed ADA Checklist with credentialing packet or fax to:
HealthCare Partners
1-516-515-8843

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date of execution hereof by Heritage New York IPA, Inc. d/b/a HealthCare Partners, IPA.

_____ **Corporate Name (if applicable)**	**Heritage New York IPA, Inc. d/b/a HealthCare Partners, IPA**
_____ **PROVIDER Signature**	**By:** _____
Print Name: _____	**Name:** _____
Title: _____	**Title:** _____
Date: _____	**Date:** _____
_____ **Telephone (no 800 numbers)**	
_____ **Federal Tax Identification Number**	

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 true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). 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. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

_____
Signature

_____
Name (Please Print or Type)

_____
Social Security Number

_____
Date

MAGNACARE

SIGNATURE PAGE FOR THE PROVIDER'S CERTIFICATION OF HIS/HER/ITS CREDENTIALING INFORMATION AND AGREEMENT TO BE BOUND BY THE TERMS OF THE PROVIDER PARTICIPATION AGREEMENT

This Signature Page shall constitute the first page of your Provider Participation Agreement (the "Agreement"). The Agreement, including this page and those that follow, constitutes a binding obligation; please read it carefully and, if you agree with its terms, please sign where indicated below to express your agreement.

I understand and agree that, as part of the credentialing application process for my acceptance to participate in the MagnaCare network and those of any of its affiliated entities (collectively, the "Network"), 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 Network for determining initial and ongoing eligibility for participation. The Network acknowledges that the information obtained relating to the application process will be held confidential to the extent required by law.

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 Network 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 as to my participation by the Network, and must be submitted online or in writing, and must be dated and signed by me. I acknowledge that the Network 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 immediate 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 Network and/or its agent(s).

I agree to be bound by the terms and conditions which are set forth in this Certification. I also agree to be bound by all of the terms and conditions in the remainder of the Agreement which are set forth below, beginning on the Effective Date denoted on my MagnaCare Network participation acceptance letter.

Provider may not make changes to this Agreement after it is signed by MagnaCare and any purported changes made by Provider will be of no force and/or effect.

PROVIDER:

Signature: _____

By (print name): _____

Title: _____

Tax ID: _____

MAGNACARE ADMINISTRATIVE SERVICES, LLC

Signature: Matthew Fienman

By: Matthew Fienman

Title: Executive Vice President

Date: ____/____/_____

NPI #: _____ LICENSE #: _____ CAQH #: _____

Primary Specialty: _____

Active Medicaid Numbers and State(s): _____

Medicare Number: _____

Provider Contact Name: Dominique Morales Provider Contact Phone #: 718-613-8487

Contact Email: Dominique.Morales@downstate.edu

One Penn Plaza
46th Floor
New York, NY 10119

1600 Stewart Avenue
Suite 700
Westbury, NY 11590

44 W. Gilbert Street
Tinton Falls, NJ
07701

2 Huntington Quadrangle
Suite 4N10
Melville, NY 11747

877.624.6220
www.magnacare.com

MAGNACARE

SIGNATURE PAGE FOR THE PROVIDER'S CERTIFICATION OF HIS/HER/ITS CREDENTIALING INFORMATION AND AGREEMENT TO BE BOUND BY THE TERMS OF THE PROVIDER PARTICIPATION AGREEMENT

This Signature Page shall constitute the first page of your Provider Participation Agreement (the "Agreement"). The Agreement, including this page and those that follow, constitutes a binding obligation; please read it carefully and, if you agree with its terms, please sign where indicated below to express your agreement.

I understand and agree that, as part of the credentialing application process for my acceptance to participate in the MagnaCare network and those of any of its affiliated entities (collectively, the "Network"), 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 Network for determining initial and ongoing eligibility for participation. The Network acknowledges that the information obtained relating to the application process will be held confidential to the extent required by law.

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 Network 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 as to my participation by the Network, and must be submitted online or in writing, and must be dated and signed by me. I acknowledge that the Network 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 immediate 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 Network and/or its agent(s).

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Provider may not make changes to this Agreement after it is signed by MagnaCare and any purported changes made by Provider will be of no force and/or effect.

PROVIDER:

Signature: _____

By (print name): _____

Title: _____

Tax ID: _____

MAGNACARE ANCILLARY SERVICES, LLC

Signature: Matthew Fienman

By: Matthew Fienman

Title: Executive Vice President

Date: ____/____/_____

NPI #: _____ LICENSE #: _____ CAQH #: _____

Primary Specialty: _____

Active Medicaid Numbers and State(s): _____

Medicare Number: _____

Provider Contact Name: DOMINIQUE MORALES Provider Contact Phone #: 718-613-8487

Contact Email: DOMINIQUE.MORALES@DOWNSTATE.EDU

One Penn Plaza, 46th Floor, New York, NY 10119 | 1600 Stewart Avenue, Suite 700, Westbury, NY 11590 | 44 W. Gilbert Street, Tinton Falls, NJ 07701 | 2 Huntington Quadrangle, Suite 4N10, Melville, NY 11747 | 877.624.6220 www.magnacare.com

FEDERAL TAX IDENTIFICATION NUMBER(S)

I _____ *(Provider Name & Title)* hereby authorize you to add my tax identification number(s) listed below to my MagnaCare participating provider profile. I understand and agree that my claims will be processed as in-network when submitted under any of these numbers. In addition, I have enclosed a signed W-9 form for each of the following numbers.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

_____ ____/____/_____

Applicant's Signature Date

One Penn Plaza
46th Floor
New York, NY 10119

1600 Stewart Avenue
Suite 700
Westbury, NY 11590

44 W. Gilbert Street
Tinton Falls, NJ
07701

2 Huntington Quadrangle
Suite 4N10
Melville, NY 11747

877.624.6220
www.magnacare.com

MAGNACARE

FEDERAL TAX IDENTIFICATION NUMBER(S)

I _____ *(Provider Name & Title)* hereby authorize you to add my tax identification number(s) listed below to my MagnaCare participating provider profile. I understand and agree that my claims will be processed as in-network when submitted under any of these numbers. In addition, I have enclosed a signed W-9 form for each of the following numbers.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

_____ Applicant's Signature

____/____/_____ Date

One Penn Plaza
46th Floor
New York, NY 10119

1600 Stewart Avenue
Suite 700
Westbury, NY 11590

44 W. Gilbert Street
Tinton Falls, NJ
07701

2 Huntington Quadrangle
Suite 4N10
Melville, NY 11747

877.624.6220
www.magnacare.com

PARTICIPATING PRACTITIONER AGREEMENT

The Plans, EmblemHealth companies defined herein, are pleased to contract with Practitioner for the provision of Covered Services to Members according to the terms and conditions of this Agreement and the Plans' Administrative Guidelines including, but not limited to, the Plans' Provider Manual and each Member's Benefit Program set forth on Attachment B. Each of the Plans and Practitioner agree to abide by the Quality Improvement, Utilization Management and other applicable rules, policies and procedures of each Plan. This Agreement (consisting collectively of this page and the Prevailing Plan Fee Schedule annexed hereto as Attachment A, plus all exhibits and other attachments, as well as the Administrative Guidelines and Provider Manual as amended from time to time and published on EmblemHealth's Web site) constitutes the complete and sole contract between each Plan and Practitioner regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. The effective date of this Agreement is _____
(For Plan use)
("Start Date"), contingent on any necessary Credentialing Committee approval. If the Practitioner is a professional corporation, this Agreement shall apply to each Member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, each of the Plans enters into this Agreement effective as of the Start Date.

HIP INSURANCE COMPANY OF NEW YORK, VYTRA HEALTH PLANS MANAGED SYSTEMS

Date: _____

PRACTITIONER

By: _____
(Signature)

Name: _____
(Print)

Date: _____

Address:

_____

_____

_____

Telephone: _____

Tax Identification #: _____

NYS License #: _____

(NPI) #: _____

Group NPI #: _____

AGREEMENT BETWEEN
HIP NETWORK SERVICES IPA, INC.
AND
PARTICIPATING PRACTITIONER

HIP Network Services IPA ("HNSIPA"), is pleased to contract with the undersigned Practitioner for the provision of Covered Services to Members. Practitioner and HNSIPA are entering into this Agreement in order for Practitioner to provide services as a Participating Provider to Members according to the terms and conditions of this Agreement, the Plan's Administrative Guidelines including but not limited to the Plan's Provider Manual and each Member's Benefit Program. HNSIPA and Practitioner agree to abide by the Quality Improvement, Utilization Management and other applicable rules, policies and procedures of the Plan with whom HNSIPA contracts to provide services. This Agreement (consisting collectively of this page, the body of the agreement that follows and the Prevailing Plan Fee Schedule annexed hereto as Attachment A, plus all other exhibits and other attachments), as well as the Administrative Guidelines and Provider Manual, as amended from time to time and published on the Plan's Web site, constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. Subject to any necessary regulatory approvals, the effective date of this Agreement is _____ ("Start Date"), contingent on any necessary Credentialing Committee approval.
(For Plan use)

If Practitioner is a professional corporation this Agreement shall apply to each member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, HNSIPA and Practitioner enter into this Agreement to be effective as of the Start Date.

HIP NETWORK SERVICES IPA, INC.

Date: _____

PRACTITIONER

By: _____
(Signature)

Name: _____
(Print)

Date: _____

Address:

_____

_____

_____

Telephone: _____

Tax Identification #: _____

NYS License #: _____

(NPI) #: _____

Group NPI #: _____

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

SPECIAL PROVISIONS RELATED TO MEDICAID AND FAMILY HEALTH PLUS MEMBERS

With respect to services rendered to the Plan's Medicaid and Family Health Plus Members (jointly referred to as "Medicaid Members"), Practitioner will be subject to all relevant obligations and duties imposed under the Plan's Medicaid contracts with the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene ("NYC DOHMH") , including the following provisions which shall apply and be binding upon the Parties:

A. Plan and Practitioner acknowledge and agree that the Plan's Medicaid Members are not subject to Medicaid utilization thresholds, or limitations on services covered by Medicaid. However, Medicaid Members may be subject to Medicaid utilization thresholds for outpatient pharmacy services that are billed Medicaid fee-for-service until such time as the Plan is required to manage and pay for such services (the Medicaid Pharmacy Carve-In Effective Date).

B. Plan and Practitioner acknowledge and agree that, with respect to the Plan's Medicaid Members, Plan and Practitioner shall comply with the informed consent procedures for hysterectomy and sterilization, as set forth at 42 C.F.R, Part 441, sub-part F and 18 N.Y.C.R.R. Section 505.13, the NYSDOH C/THP Manual and all applicable public health laws and regulations including, without limitation, the reporting of communicable diseases. Practitioner acknowledges and agrees that compliance with this provision shall be audited by Plan and the Plan in connection with its quality assurance review of Practitioner.

C. Plan and Practitioner acknowledge and agree that, with respect to the Plan's Medicaid Members, the Plan retains the right to audit Practitioner's claims for a six (6) year period from the date of care, services or supplies were provided or billed, whichever is later and to recoup any overpayments discovered as a result of the audit. This six (6) year limitation does not apply to situations in which fraud may be involved or in which the Practitioner or an agent of the Practitioner prevents or obstructs the Plan's auditing. Effective July 1, 2007, this policy also applies to recovery of overpayments to provider for Child Health Plus Members.

D. Practitioners treating Members enrolled in Medicaid agree and acknowledge that they must comply with the following guidelines for member-to-provider ratios, which are based on the assumption that the Practitioner practices full-time (forty (40) hours per week). These ratios are practitioner-specific and must be prorated for practitioners practicing less than forty (40) hours per week. The ratios apply to practitioners, not to each of their practice locations.

   1. Practitioners who are physicians shall have no more than 1,500 Members on their panel or 2,400 for a physician practicing in combination with a registered physician assistant or certified nurse practitioner.

   2. Advanced Nurse Practitioners credentialed as Primary Caregivers shall have no more than 1,000 Members on their panel.

E. Practitioner acknowledges and agrees that the provisions set forth in the Agreement regarding prior approval of elective services shall not apply to the Plan's Medicaid Members seeking services to which Members may self refer to Family Planning and Reproductive Health Services, including without limitation, pre and post–test HIV counseling and blood testing.

AGREEMENT BETWEEN
GROUP HEALTH INCORPORATED
AND
PARTICIPATING PROVIDER

Group Health Incorporated (GHI), an EmblemHealth company, is pleased to contract with the undersigned Provider for the provision of Covered Services to Members. Provider and GHI are entering into this Agreement in order for Provider to provide Plan Services as a Participating Provider to Members according to the terms and conditions of this Agreement, the Administrative Guidelines, including but not limited to EmblemHealth's Provider Manual and each Member's Benefit Program. GHI and Provider agree to abide by the Quality Improvement, Utilization Management and other applicable rules, policies and procedures of GHI and the Plans with whom GHI contracts to provide services. This Agreement (consisting collectively of this page, the body of the agreement that follows and the Reimbursement Schedule annexed hereto as Exhibit B plus all other exhibits and other attachments) constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. The effective date of this Agreement (contingent on Emblem's Credentialing Committee approval) is _____ ("Start Date"). If Provider is a professional corporation this Agreement shall apply to each member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, GHI and Provider enter into this Agreement to be effective as of the Start Date.

Group Health Incorporated	PROVIDER
By:	**By:** _____ (Signature)
	Name: _____ (Print)
	Date: _____
	Address: _____
Date: _____	**Telephone:** _____
	E-mail: _____
	Tax Identification #: _____
	State License #: _____
	(NPI) #: _____
	Group NPI #: _____

AGREEMENT BETWEEN
GHI HMO SELECT, INC. AND PARTICIPATING PROVIDER

GHI HMO Select, Inc. (GHI HMO or Plan) is pleased to contract with the undersigned Provider for the provision of Covered Services to Members. Provider and GHI HMO are entering into this Agreement in order for Provider to provide services as a Participating Provider to Members according to the terms and conditions of this Agreement, the Plan's Administrative Guidelines, including but not limited to the Plan's Provider Manual, and each Member's Benefit Program. GHI HMO and Provider agree to abide by the Quality Improvement, Utilization Management and other applicable rules, policies and procedures of the Plan. This Agreement (consisting collectively of this page, the body of the agreement that follows and the Prevailing Plan Fee Schedule annexed hereto as Attachment A, plus all other exhibits and other attachments), as well as the Administrative Guidelines and Provider Manual, as amended from time to time and published on the Plan's Web site, constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. Subject to any necessary regulatory approvals, the effective date of this Agreement is _____ ("Start Date"),
(For Plan Use)
contingent on any necessary Credentialing Committee approval. If Provider is a professional corporation, this Agreement shall apply to each member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, GHI HMO and Provider enter into this Agreement to be effective as of the Start Date.

APPENDIX I – CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into of any cooperative agreement or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Provider		
By *(Signature)*		
Name *(Print)*		Date
Organization		
Address		
Telephone	NYS License #:	
Tax ID #	NPI #	Group NPI #

GHI HMO Select, Inc.
Date

The American with Disabilities Act (ADA) Attestation

Provider Name (print): Date:
Provider Signature:
Provider Address:
Specialty:

1. Does the office have at least one wheelchair-accessible path from an entrance to an exam room? Yes No

2. Examination tables and all equipment are accessible to people with disabilities. Yes No

3. If parking is provided, spaces are reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs? Yes No

4. If parking is provided, are there an adequate number of parking spaces provided (8 feet wide for a car and 5 foot access aisle)? Yes No

Total Spaces	accessible Spaces
1-25	1
26-50	2
51-75	3
76-100	4

5. For a provider with a disability-accessible parking space, is there a path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs? Yes NO
   - Is the path of travel stable, firm and slip resistant? Yes No
   - Except for curb cuts, is the path at least 36 inches wide? Yes No

6. Is there a method for persons using wheelchairs or that require other mobility assistance to enter as freely as everyone else? Yes No
   - Is that route of travel safe and accessible for everyone, including people with disabilities? Yes No

7. Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following standards:
   - 32 inches clear opening. Yes No
   - 18 inches of clear wall space on the pull side of the door, next to the handle. Yes No
   - The threshold edge is no greater than ¼ inch high or if beveled, no greater than ¾ inches high. Yes No
   - The door handle is no higher than 48 inches high and can be operated with a closed fist. Yes No

8. Are there ramps to permit wheelchair access? Yes No
   If yes, complete the following 4 questions:
   - Are the slopes of the ramp accessible for wheelchair access? Yes No
   - Are the railings sturdy and high enough for wheelchair access? Yes No

- Is the width between railings wide enough to accommodate a wheelchair? Yes No
- Are the ramps nonslip and free from any obstruction (cracks)? Yes No

9. If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance? Yes No

10. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? Yes No

11. Can the accessible entrance be used independently and without assistance? Yes No

12. Are doormats ½ inch high or less with beveled or secured edges? Yes No

13. Are waiting rooms and exam rooms accessible to people with disabilities? Yes No

14. The layout of the interior of the building allows people with disabilities to obtain materials and services without assistance. Yes No

15. The interior doors comply with the criteria set forth above regarding the exterior door. Yes No

16. The accessible routes to all public spaces in the facility are 31 inches wide. Yes No

17. There is a 5 foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered. Yes No

18. All buttons or other controls in the hallway are no higher than 42 inches. Yes No

19. Elevators in the facility meet the following standards:
    - There are raised and Braille signs on both door jambs on every floor. Yes No
    - The call buttons in the hallway are not higher than 42 inches. Yes No
    - The controls inside the cab have raised and Braille lettering. Yes No

20. Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances? Yes No

21. Is the public lavatory wheelchair-accessible? Yes No

22. With respect to the public restroom, the accessible route, the exterior door and the interior stall doors comply with standards set forth above for exterior doors. Yes No

23. There is at least one wheelchair accessible stall in the public restroom that has an area of at least 5 feet by 5 feet, clear of the door swing; OR there is at least one stall that is less accessible but that provides greater access than a typical stall (either 36 by 69 inches, or 48 by 69 inches). Yes No

24. In the accessible stall of the public rest room there are grab bars behind and on the side wall nearest the toilet. Yes No

25. There is one lavatory in the public restroom that meets the following standards:
    - 30 inches wide by 48 inches; deep bar space in front.
    - (A maximum of 19 inches of the required depth may be under the lavatory.) Yes No
    - The lavatory rim is no higher than 34 inches. Yes No
    - There is at least 29 inches from the floor to the bottom of the lavatory apron. Yes No
    - The faucet can be operated with a closed fist. Yes No
    - The soap dispenser and hand dryers are within reach and usable with one closed fist. Yes No
    - The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower. Yes No

I, [First and Last Names, Title, Provider Name], hereby attest that we are a provider that has a physical site at which FIDA Participants might possibly be physically present and that the answers provided are accurate. Also, I do hereby attest that I hold the authority to make these attestations.

Provider Name (print)_____ Date:

Provider Signature _____