



APPLICATION FOR PARTICIPATION IN  
NEWYORK-PRESBYTERIAN  
COMMUNITY HEALTH PLAN

**THE FOLLOWING DOCUMENTS ARE REQUIRED  
BEFORE THIS APPLICATION CAN BEGIN  
THE VERIFICATION PROCESS:**

- **COPY OF CURRENT MEDICAL REGISTRATION CERTIFICATE**
- **DEA CERTIFICATE**
- **TAX I.D. CERTIFICATE (W-9 FORM)**
- **BOARD CERTIFICATION CERTIFICATE**
- **MALPRACTICE INSURANCE FACE SHEET**
- **CURRICULIM VITAE**
- **MALPRACTICE HISTORY**

**PHYSICIAN IDENTIFICATION**

PHYSICIAN NAME: (LAST, FIRST, MIDDLE)		DATE OF BIRTH: (Month/Day/Year)	
DEGREE <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> OTHER _____	SOCIAL SECURITY NO.:	CITIZENSHIP:	GENDER:

**PRACTICE IDENTIFICATION**

ARE YOU APPLYING AS:

**PRIMARY CARE PHYSICIAN** (Internal Medicine, Family Practice, Pediatrics, Adolescent Medicine, Nurse Practitioner-Adult Health, Family Health, Pediatrics)

**SPECIALIST** FOR DIRECTORY PURPOSES, PLEASE SPECIFY THE PRINCIPAL FIELDS OF SPECIALIZATION FOR WHICH YOU WOULD LIKE TO BE LISTED:

\_\_\_\_\_

**BOTH**

**PRACTICE INFORMATION**

PLEASE LIST ALL OFFICES OR GROUPS WHERE YOU CURRENTLY PRACTICE (ATTACH ADDITIONAL SHEETS IF NECESSARY.)

PRIMARY OFFICE/GROUP				SECONDARY OFFICE/GROUP			
OFFICE/GROUP NAME				OFFICE/GROUP NAME			
OFFICE/GROUP ADDRESS				OFFICE/GROUP ADDRESS			
CITY/TOWN	STATE	ZIP		CITY/TOWN	STATE	ZIP	
TELEPHONE NO. (   )	FAX NO. (   )			TELEPHONE NO. (   )	FAX NO. (   )		

**BILLING INFORMATION**

PLEASE PROVIDE BILLING INFORMATION FOR EACH TAX IDENTIFICATION NUMBER UNDER WHICH YOU CURRENTLY BILL (ATTACH ADDITIONAL SHEETS IF NECESSARY.)

PRIMARY BILLING				SECONDARY BILLING			
MEDICAID #				MEDICAID #			
TAX ID #				TAX ID #			
PAYMENT NAME <input type="checkbox"/> SAME AS "PRIMARY" ABOVE				PAYMENT NAME <input type="checkbox"/> SAME AS "SECONDARY" ABOVE			
PAYMENT ADDRESS				PAYMENT ADDRESS			
CITY/TOWN	STATE	ZIP		CITY/TOWN	STATE	ZIP	
TELEPHONE NO.				TELEPHONE NO.			
FAX NO.				FAX NO.			

**OFFICE HOURS (Required for PCPs)/HANDICAPPED ACCESS/PANEL STATUS:**

PRIMARY OFFICE								SECONDARY OFFICE							
MON.	TUE.	WED.	THURS.	FRI.	SAT.	SUN.	HANDICAPPED ACCESS	MON.	TUE.	WED.	THURS.	FRI.	SAT.	SUN.	HANDICAPPED ACCESS

ARE YOU ACCEPTING NEW PATIENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU ACCEPTING NEW PATIENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
SPECIFY THE AGE RANGES OF PATIENTS TREATED <input type="checkbox"/> PEDIATRIC 0 – 18 <input type="checkbox"/> ADOLESCENT MEDICINE 12 – 19 <input type="checkbox"/> ADULT 19+ <input type="checkbox"/> ALL AGES	SPECIFY THE AGE RANGES OF PATIENTS TREATED <input type="checkbox"/> PEDIATRIC 0 – 18 <input type="checkbox"/> ADOLESCENT MEDICINE 12 – 19 <input type="checkbox"/> ADULT 19+ <input type="checkbox"/> ALL AGES

PLEASE LIST ALL THE HOSPITALS AT WHICH YOU ADMIT PATIENTS. (ATTACH ADDITIONAL SHEETS IF NECESSARY.)		
A. PRIMARY AFFILIATION	CITY	DEPT.
B. SECONDARY AFFILIATION	CITY	DEPT.
C. THIRD AFFILIATION	CITY	DEPT.
D. FOURTH AFFILIATION	CITY	DEPT.

<b>FOREIGN LANGUAGES SPOKEN FLUENTLY:</b>
BY MYSELF:
BY MY STAFF:
BY MY PARTNER(S) IN THE SAME OFFICE LOCATION:

<b>WHAT IS THE LEAD TIME FOR SCHEDULING:</b>
_____ INITIAL VISIT    _____ NON-URGENT APPOINTMENTS    _____ URGENT APPOINTMENTS    _____ PHYSICAL EXAMS

<b>PRACTICE COVERAGE PROVIDED BY (PLEASE LIST)</b>
NAME _____ LICENSE # _____
NAME _____ LICENSE # _____
NAME _____ LICENSE # _____
NAME _____ LICENSE # _____

24 hour per day-7 day per week coverage is required. Please list physicians who provide coverage when you are not on call. Referral to the Emergency Room is not acceptable as a coverage arrangement. Covering physicians should participate in the Network, and must agree to network fees and administrative procedures.

**REFERRAL INFORMATION**

PLEASE LIST PHYSICIANS TO WHOM YOU REGULARLY REFER PATIENTS. PLEASE MAKE THIS LIST AS COMPLETE AS POSSIBLE. USE ADDITIONAL PAGES IF NECESSARY. THIS WILL HELP US RECRUIT ADDITIONAL PHYSICIANS, AS NECESSARY.			
PHYSICIAN NAME	MAILING ADDRESS	TELEPHONE	SPECIALTY
1.			
2.			
3.			
4.			
5.			
6.			

ARE IN-OFFICE DIAGNOSTIC IMAGING SERVICES PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIFY THE CLINICAL REFERENCE LABORATORIES YOU USE _____ _____ _____
TYPE _____	
ARE IN-OFFICE LABORATORY STUDIES PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

## COMPUTER CAPABILITIES

DO YOU USE A COMPUTER TO FILE INSURANCE CLAIMS?  YES  NO

IF YES, NAME OF SOFTWARE OR PRACTICE MANAGEMENT PROGRAM: \_\_\_\_\_

DO YOU USE A SERVICE BUREAU TO FILE CLAIMS?  YES  NO

IF YES, NAME OF SERVICE BUREAU: \_\_\_\_\_

SPECIFY THOSE MANAGED CARE PROGRAMS IN WHICH YOU CURRENTLY PARTICIPATE:

- Health Plus       Healthfirst       Metro Plus       HIP       St. Barnabas/Partners in Health  
 AmeriChoice       Care Plus       Fidelis       Centercare  
 Neighborhood       Community Premier Plus       Affinity       Wellcare

OTHER/SPECIFY: \_\_\_\_\_

## PROFESSIONAL EDUCATION/TRAINING

### MEDICAL SCHOOL OR PROFESSIONAL TRAINING:

NAME OF INSTITUTION: \_\_\_\_\_

ADDRESS (CITY, STATE, COUNTRY) \_\_\_\_\_

DEGREE RECEIVED: \_\_\_\_\_

GRADUATED (DATE/MONTH/YR.) \_\_\_\_\_

ECFMG CERTIFICATE  YES  NO  
If yes provide Certificate # and date issued

### INTERNSHIP:

TYPE

- Rotating       Clinical (specify area)

NAME OF INSTITUTION: \_\_\_\_\_

ADDRESS (CITY, STATE, COUNTRY) \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
(Month/Date/Year) (Month/Date/Year)

### RESIDENCY:

NAME OF PROGRAM: \_\_\_\_\_

NAME OF INSTITUTION: \_\_\_\_\_

ADDRESS (CITY, STATE, COUNTRY) \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
(Month/Date/Year) (Month/Date/Year)

### SECOND RESIDENCY:

NAME OF PROGRAM: \_\_\_\_\_

NAME OF INSTITUTION: \_\_\_\_\_

ADDRESS (CITY, STATE, COUNTRY) \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
(Month/Date/Year) (Month/Date/Year)

### THIRD RESIDENCY/FELLOWSHIP:

TYPE

NAME OF PROGRAM: \_\_\_\_\_

NAME OF INSTITUTION: \_\_\_\_\_

ADDRESS (CITY, STATE, COUNTRY) \_\_\_\_\_

FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
(Month/Date/Year) (Month/Date/Year)

## BOARD STATUS

PLEASE INDICATE YOUR SPECIALTY BOARD CERTIFICATION STATUS:			
	SPECIALTY 1	SPECIALTY 2	SPECIALTY 3
NAME OF CERTIFYING BOARD:			
DATE OF CERTIFICATION:			
DATE OF RECERTIFICATION:			
EXPIRATION DATE: (N/A IF NO EXPIRATION)			
IF CERTIFICATION HAS NOT YET BEEN ACHIEVED, PLEASE INDICATE YOUR PRESENT STATUS:			
WILL BE ELIGIBLE TO TAKE BOARD EXAMS: (YEAR)	DATE(S) EXAMINATION WAS TAKEN:	DATE EXAMINATION IS SCHEDULED:	
NAME OF BOARD:	SPECIALTY:		
<input type="checkbox"/> NOT PLANNING TO TAKE BOARD EXAMS.			

## DEA CERTIFICATE

STATE CERTIFICATE NUMBER	EXPIRATION DATE	PROFESSIONAL LICENSING AGENCY	STATE	LICENSE #	EXPIRATION DATE
		1.			
FEDERAL CERTIFICATE NUMBER	EXPIRATION DATE	2.			

## STATE LICENSURE

## MALPRACTICE INSURANCE

INDICATE YOUR MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE CARRIER AND PRESENT COVERAGE.		
INSURANCE CARRIER:		
AMOUNTS:	OCCURRENCE/AGGREGATE	EXPIRATION DATE:
POLICY NUMBER:		

## HISTORICAL DATA

<p>1. Have you ever had your license suspended, revoked, or subject to probation, conditions or limitations? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been censured by a Medical Society or other professional board or association? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Have you ever had your Drug Enforcement Administration number (DEA#) suspended or terminated? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Have you ever had an agreement with Medicare or Medicaid that was suspended or terminated? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Have you ever been convicted of a criminal offense, other than minor traffic violations? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Has any hospital ever: (1) dismissed you from its staff (2) revoked or suspended your general admitting privileges, or (3) initiated either type of action by formal notice to you or your representative? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>7. Has any hospital ever: (1) withdrawn permission for you to perform any procedures or tests, (2) required that another physician evaluate any patients before you performed a procedure or test (3) required another physician to be physically present when you examined a patient or performed any procedures or tests, and/or (4) initiated any action against you in any if these preceding three areas by formal notice to you or your representative? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>8. To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><b>Note: If you answer "YES" to any of the questions in this section, provide details.</b></p>	<p>9. MALPRACTICE INFORMATION:</p> <p>A. Are you presently involved in any malpractice suits? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>B. Have you ever been involved in any malpractice suits? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>C. Has any payment been made by you, or on your behalf, as a result of a malpractice settlement not involving litigation, a settlement that occurred prior to a judgement involving litigation, or a settlement that was the result of a judgement involving litigation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>D. If "YES" details provided should include when each action or proceeding was instituted and the status or outcome of each including the date and amount of any judgement, adverse decision or settlement, together with copies of the same.</p> <p>10. Do you have any physical or mental health conditions, treated or untreated, which in any way impairs your ability to practice to the fullest extent of your licensure and qualifications or in any way poses a risk of harm to your patients? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>11. Do you have or have you had a chemical dependency/substance abuse problem, treated or untreated? If "YES" please provide details. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>_____ SIGNATURE</p> <p>_____ NAME (PLEASE PRINT OR TYPE)</p> <p>_____ DATE</p>
---	---

**DECLARATION BY APPLICANT**

I hereby submit this application to be a participating provider in NewYork-Presbyterian Community Health Plan and in managed care programs maintained or contracted by NewYork-Presbyterian Community Health Plan and I understand that my application will be reviewed based on the information I have provided here. If there is any change in this information prior to the acceptance of this application, I will provide such updated information as a supplement to this application. I hereby certify that the information contained in this form, as it may be supplemented, is accurate and true, and that information found to be false or omitted could result in a denial, or a subsequent termination of my participation.

In order for NewYork-Presbyterian Community Health Plan to evaluate this application and/or my continued participation in NewYork-Presbyterian Community Health Plan and in managed care programs, I hereby authorize NewYork-Presbyterian Community Health Plan and its agents to contact and request information from persons having information regarding my professional credentials and qualifications. Persons who may be contacted for information include hospitals of which I have/had staff privileges, and the chiefs of clinical departments of such hospitals, professional certification boards, The National Practitioner Data Bank, state regulatory and licensing departments, professional liability insurance carriers and my current or past employers.

I consent to the release and disclosure by such persons of information concerning my credentials and qualifications to NewYork-Presbyterian Community Health Plan or its agents or, as directed by NewYork-Presbyterian Community Health Plan to managed care organizations and other maintaining managed care programs in which I may participate.

The above authorization and consent is based upon my understanding that the use of all information released or disclosed will be for the administration of, and my participation in, managed care programs maintained or contracted by NewYork-Presbyterian Community Health Plan.

A photocopy of this declaration will be as valid as this original.

I agree that submission of this application does not constitute approval or acceptance of me as a participating provider in NewYork-Presbyterian Community Health Plan and grants me no rights or privileges in any program until such time as I receive notice of acceptance of this application and I have entered into a separate Participating Physician Agreement with NewYork-Presbyterian Community Health Plan. I also understand that this is not an application for privileges at NewYork-Presbyterian Hospital.

I attest to the correctness and completeness of this application.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME (PLEASE PRINT OR TYPE)

**APPLICATION FOR PARTICIPATION IN  
NEWYORK-PRESBYTERIAN COMMUNITY HEALTH PLAN**

CONTACT PERSON

NAME OF PERSON(S) TO BE CONTACTED IF FURTHER INFORMATION OR CLARIFICATION IS NEEDED:

LAST

FIRST

PHONE NO.

FAX NO.