

# Provider Credentialing Form



EmblemHealth®

ConnectiCare

Tell us about your practice and how you would like to participate with our plan(s).

<b>Provider Last Name:</b>	<b>Provider First Name:</b>	<b>Gender:</b>
<b>Title (check appropriate boxes):</b> <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/> PA <input type="checkbox"/> NP/APRN <input type="checkbox"/> DPM <input type="checkbox"/> Other:		
<b>NPI:</b>	<b>CAQH ID #:</b>	
<b>Who should we contact if we have questions about this application?</b>		
<b>Credentialing Contact:</b>	<b>Credentialing Email:</b>	<b>Credentialing Phone:</b>
<b>Company(ies) Applying To</b> Please see our Provider Participation by Line of Business Map to see the geographic areas our networks cover. Only select the companies whose networks match your service location(s) and the members you serve. <b>ConnectiCare</b> <input type="checkbox"/> ConnectiCare, Inc. and affiliates* *Plans are only offered in Connecticut, Rhode Island, and the following Massachusetts counties: Berkshire, Franklin, Hampden, and Hampshire. <b>EmblemHealth*</b> <input type="checkbox"/> EmblemHealth Plan, Inc. (formerly GHI) Submit signed contract documents with application. Download the <a href="#">EmblemHealth Plan, Inc. Participating Practitioner Agreement</a> . <input type="checkbox"/> Health Insurance Company of Greater New York** and EmblemHealth Insurance Company*** Submit signed contract documents with application. *If you are applying for EmblemHealth and do not have a group contract, you must attach the applicable signature page for each company selected above. **If you are eligible for participation in any of these networks, a contract will be sent to you. ***Plans are only offered in the following New York counties: Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, Orange, Otsego, Putnam, Queens, Ulster, Westchester, Warren, Washington, Schoharie, Schenectady, Richmond, Rockland, Rensselaer, Saratoga, Suffolk, Sullivan, Nassau, and New York.		

<b>Practitioner Type: (select one)</b> <input type="checkbox"/> Primary Care Provider (PCP) - Number of working hours per week: _____ <input type="checkbox"/> Dual PCP/Specialist - Number of working hours per week: _____ <input type="checkbox"/> Specialist	<b>Are you accepting new patients?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Board certified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, please list board(s):
<b>Specialty to appear in the directory:</b>	

<b>Advanced Practice Clinicians and Allied Health Professionals Only</b>	
<b>APRN/NP</b> Submit nursing certification with application.	
<b>APRN/NP/PA/Midwife</b> Indicate name and National Provider Identifier (NPI) of collaborating physician or submit a collaborative practice agreement with application.	
<b>Collaborating Physician Name:</b>	<b>Collaborating Physician NPI:</b>
<b>Massachusetts PA PCPs</b> Submit your PA certification and collaborative practice agreement with your application.	

<b>Joining a group practice?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Group Name:</b>
<b>Do you practice exclusively in an inpatient setting (i.e., patients cannot call and make an appointment to see you)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list hospital:	

## Tell us about your practice locations.

PRIMARY LOCATION		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	State:	ZIP:
Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Enter Taxpayer Identification Number (TIN): _____ Submit W-9 with application. Download W-9 Form ( <a href="http://www.irs.gov/forms-instructions">www.irs.gov/forms-instructions</a> ) <b>Note:</b> TIN and W-9 are required for each service location.		
Phone number for appointment scheduling:	Email address for plan notifications:	
<b>Place of Service:</b> <input type="checkbox"/> In office. <input type="checkbox"/> Homeless shelter (not shown in our directories). <input type="checkbox"/> Inpatient hospital (not shown in our directories). <input type="checkbox"/> Domestic violence shelter (not shown in our directories). <input type="checkbox"/> Outpatient hospital (not shown in our directories). <input type="checkbox"/> Veteran's administration facility (not shown in our directories). <input type="checkbox"/> Ambulatory surgical center (not shown in our directories). <input type="checkbox"/> Virtual (not shown in our directories). <input type="checkbox"/> Home-based services (not shown in our directories). <input type="checkbox"/> School-based (not shown in our directories). <input type="checkbox"/> Skilled nursing facility (not shown in our directories). <input type="checkbox"/> Non-appointment-based location (not shown in our directories).		
Do you see patients on a regular and consistent basis, at least one day a week, at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you applying to participate at all locations on your CAQH Application?

- Yes (Skip the **Additional Offices** section.)  
 No (Complete the following information for each additional office you would like us to consider.)

ADDITIONAL OFFICE #1		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	State:	ZIP:
Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Enter Taxpayer Identification Number (TIN): _____ Submit W-9 with application. Download W-9 Form ( <a href="http://www.irs.gov/forms-instructions">www.irs.gov/forms-instructions</a> ) <b>Note:</b> TIN and W-9 are required for each service location.		
Phone number for appointment scheduling:	Email address for plan notifications:	
<b>Place of Service:</b> <input type="checkbox"/> In office. <input type="checkbox"/> Homeless shelter (not shown in our directories). <input type="checkbox"/> Inpatient hospital (not shown in our directories). <input type="checkbox"/> Domestic violence shelter (not shown in our directories). <input type="checkbox"/> Outpatient hospital (not shown in our directories). <input type="checkbox"/> Veteran's administration facility (not shown in our directories). <input type="checkbox"/> Ambulatory surgical center (not shown in our directories). <input type="checkbox"/> Virtual (not shown in our directories). <input type="checkbox"/> Home-based services (not shown in our directories). <input type="checkbox"/> School-based (not shown in our directories). <input type="checkbox"/> Skilled nursing facility (not shown in our directories). <input type="checkbox"/> Non-appointment-based location (not shown in our directories).		
Do you see patients on a regular and consistent basis, at least one day a week, at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ADDITIONAL OFFICE #2		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	State:	ZIP:
Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Enter Taxpayer Identification Number (TIN): _____ Submit W-9 with application. Download W-9 Form ( <a href="http://www.irs.gov/forms-instructions">www.irs.gov/forms-instructions</a> ) <b>Note:</b> TIN and W-9 are required for each service location.		
Phone number for appointment scheduling:	Email address for plan notifications:	
<b>Place of Service:</b> <input type="checkbox"/> In office. <input type="checkbox"/> Homeless shelter (not shown in our directories). <input type="checkbox"/> Inpatient hospital (not shown in our directories). <input type="checkbox"/> Domestic violence shelter (not shown in our directories). <input type="checkbox"/> Outpatient hospital (not shown in our directories). <input type="checkbox"/> Veteran's administration facility (not shown in our directories). <input type="checkbox"/> Ambulatory surgical center (not shown in our directories). <input type="checkbox"/> Virtual (not shown in our directories). <input type="checkbox"/> Home-based services (not shown in our directories). <input type="checkbox"/> School-based (not shown in our directories). <input type="checkbox"/> Skilled nursing facility (not shown in our directories). <input type="checkbox"/> Non-appointment-based location (not shown in our directories).		
Do you see patients on a regular and consistent basis, at least one day a week, at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ADDITIONAL OFFICE #3		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	State:	ZIP:
Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Enter Taxpayer Identification Number (TIN): _____ Submit W-9 with application. Download W-9 Form ( <a href="http://www.irs.gov/forms-instructions">www.irs.gov/forms-instructions</a> ) <b>Note:</b> TIN and W-9 are required for each service location.		
Phone number for appointment scheduling:	Email address for plan notifications:	
<b>Place of Service:</b> <input type="checkbox"/> In office. <input type="checkbox"/> Homeless shelter (not shown in our directories). <input type="checkbox"/> Inpatient hospital (not shown in our directories). <input type="checkbox"/> Domestic violence shelter (not shown in our directories). <input type="checkbox"/> Outpatient hospital (not shown in our directories). <input type="checkbox"/> Veteran's administration facility (not shown in our directories). <input type="checkbox"/> Ambulatory surgical center (not shown in our directories). <input type="checkbox"/> Virtual (not shown in our directories). <input type="checkbox"/> Home-based services (not shown in our directories). <input type="checkbox"/> School-based (not shown in our directories). <input type="checkbox"/> Skilled nursing facility (not shown in our directories). <input type="checkbox"/> Non-appointment-based location (not shown in our directories).		
Do you see patients on a regular and consistent basis, at least one day a week, at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**ADDITIONAL OFFICE #4**

Name of Practice or Facility:

Address 1:

Address 2:

City:	State:	ZIP:
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Can patients make appointments with you at this address?  Yes  No

Enter Taxpayer Identification Number (TIN): \_\_\_\_\_  
 Submit W-9 with application. Download W-9 Form ([www.irs.gov/forms-instructions](http://www.irs.gov/forms-instructions))  
**Note:** TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	Email address for plan notifications:
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**Place of Service:**

<input type="checkbox"/> In office.	<input type="checkbox"/> Homeless shelter (not shown in our directories).
<input type="checkbox"/> Inpatient hospital (not shown in our directories).	<input type="checkbox"/> Domestic violence shelter (not shown in our directories).
<input type="checkbox"/> Outpatient hospital (not shown in our directories).	<input type="checkbox"/> Veteran's administration facility (not shown in our directories).
<input type="checkbox"/> Ambulatory surgical center (not shown in our directories).	<input type="checkbox"/> Virtual (not shown in our directories).
<input type="checkbox"/> Home-based services (not shown in our directories).	<input type="checkbox"/> School-based (not shown in our directories).
<input type="checkbox"/> Skilled nursing facility (not shown in our directories).	<input type="checkbox"/> Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location?  Yes  No**ADDITIONAL OFFICE #5**

Name of Practice or Facility:

Address 1:

Address 2:

City:	State:	ZIP:
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Can patients make appointments with you at this address?  Yes  No

Enter Taxpayer Identification Number (TIN): \_\_\_\_\_  
 Submit W-9 with application. Download W-9 Form ([www.irs.gov/forms-instructions](http://www.irs.gov/forms-instructions))  
**Note:** TIN and W-9 are required for each service location.

Phone number for appointment scheduling:	Email address for plan notifications:
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**Place of Service:**

<input type="checkbox"/> In office.	<input type="checkbox"/> Homeless shelter (not shown in our directories).
<input type="checkbox"/> Inpatient hospital (not shown in our directories).	<input type="checkbox"/> Domestic violence shelter (not shown in our directories).
<input type="checkbox"/> Outpatient hospital (not shown in our directories).	<input type="checkbox"/> Veteran's administration facility (not shown in our directories).
<input type="checkbox"/> Ambulatory surgical center (not shown in our directories).	<input type="checkbox"/> Virtual (not shown in our directories).
<input type="checkbox"/> Home-based services (not shown in our directories).	<input type="checkbox"/> School-based (not shown in our directories).
<input type="checkbox"/> Skilled nursing facility (not shown in our directories).	<input type="checkbox"/> Non-appointment-based location (not shown in our directories).

Do you see patients on a regular and consistent basis, at least one day a week, at this location?  Yes  No

ADDITIONAL OFFICE #6		
Name of Practice or Facility:		
Address 1:		
Address 2:		
City:	State:	ZIP:
Can patients make appointments with you at this address? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Enter Taxpayer Identification Number (TIN): _____ Submit W-9 with application. Download W-9 Form ( <a href="http://www.irs.gov/forms-instructions">www.irs.gov/forms-instructions</a> ) <b>Note:</b> TIN and W-9 are required for each service location.		
Phone number for appointment scheduling:	Email address for plan notifications:	
<b>Place of Service:</b> <input type="checkbox"/> In office. <input type="checkbox"/> Homeless shelter (not shown in our directories). <input type="checkbox"/> Inpatient hospital (not shown in our directories). <input type="checkbox"/> Domestic violence shelter (not shown in our directories). <input type="checkbox"/> Outpatient hospital (not shown in our directories). <input type="checkbox"/> Veteran's administration facility (not shown in our directories). <input type="checkbox"/> Ambulatory surgical center (not shown in our directories). <input type="checkbox"/> Virtual (not shown in our directories). <input type="checkbox"/> Home-based services (not shown in our directories). <input type="checkbox"/> School-based (not shown in our directories). <input type="checkbox"/> Skilled nursing facility (not shown in our directories). <input type="checkbox"/> Non-appointment-based location (not shown in our directories).		
Do you see patients on a regular and consistent basis, at least one day a week, at this location? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### Submit your application and supporting documents.

After you complete this form, save it as a PDF and submit it by email to the appropriate email address below. You must include the W-9s for each TIN referenced above.

**EmblemHealth:** Also email your completed contract agreement(s) if applicable to: [credentialingnyc@emblemhealth.com](mailto:credentialingnyc@emblemhealth.com).

**ConnectiCare:** [ccicredentialing@connecticare.com](mailto:ccicredentialing@connecticare.com)

### What happens next?

Applicants have the right to review the information submitted in support of their application and to correct erroneous information. EmblemHealth/ConnectiCare will notify the applicant of any information obtained during the credentialing process that varies substantially from the information submitted.

**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 60 days before checking the status of your application by calling our Provider Customer Services team:

EmblemHealth: **866-447-9717**

ConnectiCare: **800-828-3407**

If you have an account for our secure provider portal, [emblemhealth.com](http://emblemhealth.com) or [connecticare.com](http://connecticare.com), you can check your practice profile to see if your participation has changed.

CAQH requires providers to validate their information every 120 days. Recredentialing occurs every three years and relies on the CAQH application. Please keep your information current and ensure EmblemHealth remains an authorized plan.

**Please note:** Aperture/Verisys performs primary source verification on behalf of EmblemHealth and ConnectiCare. They may contact you if additional information is required.