Fidelis Care New York

Practitioner Application
Using
CAQH Universal Credentialing DataSource
Checklist

You are required to complete the initial credentialing process for participation status. To begin the credentialing process for Fidelis Care using **CAQH Universal Credentialing DataSource**, please complete the below information and submit the applicable documents. In order for Fidelis Care to access your CAQH data, please **authorize** Fidelis Care in the "Authorize Tab" as a participating organization and **re-attest** (if applicable).

A health care professional who is newly licensed in New York State or recently relocated to New York from another State and has not previously practiced in New York and who join a group practice can receive "Provisional Credential" status if the credentialing process has not been completed within 90 days.

A "provisionally credentialed" practitioner may not be designated as a primary care provider (PCP) with his/her panel status "**closed**" to membership.

Should the application ultimately be denied, the health care professional or the group practice must agree to refund any payments made by Fidelis Care for in-network services delivered by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the enrollee's contract.

In addition, pursuant to the group practice's provider agreement with Fidelis Care, the health care professional or provider group shall not pursue reimbursement from the enrollee, except to collect the co-payment that otherwise would have been payable had the enrollee received services from a health care professional participating in the in-network portion of a health plan's network.

Interest and penalties pursuant to Section 3224a of the Insurance Law shall not be assessed based on the denial of a claim submitted during the period when the health care professional was provisionally credentialed; provided, however, that nothing herein shall prevent Fidelis Care from paying a claim from a health care professional who is provisionally credentialed upon submission of such claim.

A health care plan shall not deny, after appeal, a claim for services provided by a provisionally credentialed health care professional solely on the ground that the claim was not timely filed.

YOUR APPLICATION WILL NOT BE PROCESSED IF YOU FAIL TO PROVIDE THE FOLLOWING INFORMATION:

- ☐ Provider Data Form (To allow Fidelis to submit your name on CAQH roster)
  Please complete page 4 for any additional practice locations
- ☐ Copy of Current Appointment/Reappointment Letter from all hospital affiliations
- ☐ Copy of Board Certificate of Specialty or letter stating eligibility status
  (IF APPLICABLE) If not board certified, copy of Residency completion certificate(s)
- ☐ Signed Medicare Attestation Form (ENCLOSED) if you have current hospital affiliations
- ☐ W9 Form
- ☐ For NP's/PA's/CNM's only: Name and phone number of your Supervising/Consulting physician
- ☐ Email Addresses (5)

Current documents unless updated with CAQH:

- ☐ Copy of Current Professional Liability Insurance Certificate specifying $1.3-$3.9 Million Coverage
- ☐ Copy of Current License Registration
- ☐ Copy of Current DEA Certificate (IF APPLICABLE)

Fidelis Care New York

Practitioner Data Form

I. GENERAL INFORMATION

Last Name	First Name	MI	(Other Name)	Degree: _____ Sex ☐Male ☐Female
Applying As: ☐Primary Care Physician ☐Specialist Physician ☐Other	Specialty: _____ _____ _____		Provider Type: (MD/DO/NP/ PA, etc) _____	DOB: ____/___/_____ Social Security #: _____-_____-_____ CAQH ID#_____

NPI Individual #:	License #: State:	DEA #:	Medicare #:
NPI Group #: 1609206010	Expiration Date: _____/_____/_____	Expiration Date: _____/_____/_____	Medicaid #:

II. PRACTICE INFORMATION

Primary Location:

Practice Type: ☐Office Based ☐ Free Standing Facility ☐InPatient Exclusively (EM/Path/Hospitalists)

Group Practice Name (If Applicable)	Street Address Line 1	Address Line 2
City	State	Zip
Telephone #	Fax #	After Hours Telephone #
Is your office Handicap Accessible? ☐Yes ☐No	Languages Spoken	
Office Hours for Provider Mon: _____AM to _____PM Tues: _____AM to _____PM Wed: _____AM to _____PM	Thurs: _____AM to _____PM Fri: _____AM to _____PM Sat: _____AM to _____PM Sun: _____AM to _____PM	Tax ID #: 47-4100823
Billing Address (Pay to/Remit Addr) Network Solutions IPA	Street P.O. Box 190416	Billing Phone # 800-272-5784
City Brooklyn	State NY	Zip 11219-0416

General Announcement/Key Contact Email Address:	info@nsipa.com
Credentialing Contact Email Address:	info@nsipa.com
Quality Reporting Email Address (ex: QCMI, Provider Report Card):	info@nsipa.com
Medical Record Email Address:	
Finance/Administrative Contact Email Address (ex: claims/payment questions, rosters, RA's):	info@nsipa.com

I confirm that I have a process in place to monitor and screen employees and staff for healthcare related criminal convictions. **Yes**

I confirm that I have a process in place to monitor and screen employees and staff against the List of Excluded Individuals (LEIE) and Excluded Parties List System (EPLS). **Yes**

Authorization Signature: **	Date: **
Printed Name:	

MEDICARE ATTESTATION FORM

ANNUAL NEW YORK STATE AND FEDERAL PHYSICIAN ACKNOWLEDGEMENT AND REQUIREMENT

NEW YORK STATE REQUIREMENT

NOTICE TO PHYSICIANS/PRACTITIONERS:

Payment to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures preformed on the patient, and for the neonates, upon birth weight or admission weight as well. These data must be documented by the patient's medical record. Anyone who misrepresents, falsifies, or conceals this information maybe subject to fine, imprisonment, or civil penalty under applicable Federal and New York State Laws.

FEDERAL MEDICARE/CHAMPUS ACKNOWLEDGEMENT

NOTICE TO PHYSICIANS/PRACTITIONERS:

Medicare/CHAMPUS payments to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal Funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

By my signature on this form, I acknowledge that I have received a copy of the above statements.

** _____
Date Handwritten

** _____
Attending Physician/Practitioner's Signature

_____
Hospital Service

_____
Physician/Practitioner's Name (Please Print)

Reviewed 2/06, 3/07, 6/07, 8/08, 01/09, 10/09, 01/11, 07/14, 2/16

ADDITIONAL PRACTICE LOCATIONS

Second Location:
Practice Type: ☐Office Based ☐ Free Standing Facility ☐InPatient Exclusively (EM/Path/Hospitalists)

Group Practice Name (If Applicable)	**Street Address Line 1**	**Address Line 2**
City	**State**	**Zip**
Telephone #	**Fax #**	**After Hours Telephone #**
Is your office Handicap Accessible? ☐**Yes** ☐**No**	**Languages Spoken**	
Office Hours for Provider **Mon: _____AM to _____PM** **Tues: _____AM to _____PM** **Wed: _____AM to _____PM**	**Thurs: _____AM to _____PM** **Fri: _____AM to _____PM** **Sat: _____AM to _____PM** **Sun: _____AM to _____PM**	**Tax ID #:** 47-4100823
Billing Address (Pay to/Remit Addr) Network Solutions IPA	**Street** P.O. Box 190416	**Billing Phone #** 800-272-5784
City Brooklyn	**State** NY	**Zip** 11219-0416

Third Location:
Practice Type: ☐Office Based ☐ Free Standing Facility ☐InPatient Exclusively (EM/Path/Hospitalists)

Group Practice Name (If Applicable)	**Street Address Line 1**	**Address Line 2**
City	**State**	**Zip**
Telephone #	**Fax #**	**After Hours Telephone #**
Is your office Handicap Accessible? ☐**Yes** ☐**No**	**Languages Spoken**	
Office Hours for Provider **Mon: _____AM to _____PM** **Tues: _____AM to _____PM** **Wed: _____AM to _____PM**	**Thurs: _____AM to _____PM** **Fri: _____AM to _____PM** **Sat: _____AM to _____PM** **Sun: _____AM to _____PM**	**Tax ID #:** 47-4100823
Billing Address (Pay to/Remit Addr) Network Solutions IPA	**Street** P.O. Box 190416	**Billing Phone #** 800-272-5784
City Brooklyn	**State** NY	**Zip** 11219-0416