PROVIDER RECRUITMENT FORM (REQUEST TO PARTICIPATE)

Please print clearly in blue or black ink.

PROVIDER INFORMATION

Please complete this section and MAIL to: Provider Relations Department, Contracting and Network Management
330 West 42nd Street, 29th Floor, New York, NY 10036-6977

or FAX to: (646) 473-7213

or EMAIL to: Providers@1199Funds.org

(Please allow 45 days from receipt for processing.)

☐ Please send me information on becoming an 1199SEIU Participating Provider. ______________________ Date **Required field*

Provider's legal name* ______________________ Provider's date of birth (for secondary validation)* ______________________

Group/Practice name ______________________ Tax ID #* ______________________

Office address* ______________________ City* ______________________ State* ______ Zip code* ______

Office telephone number* ______________________ Office fax number ______________________

Office contact ______________________ Office contact's email address* ______________________

Credentialing contact ______________________ Credentialing contact's telephone number ______________________

Credentialing contact's email address ______________________

Primary specialty* ______________________ Secondary specialty ______________________

Board status ______________________ Individual national provider identifier (NPI) - must be 10 digits ______________________

Hospital affiliation ______________________ CAQH ID # ______________________

☐ I have attached documents that fulfill the following requirements:

- Attestation is within 120 days and not older than 180 days
- Current insurance facesheet
- Signed Affirmation and/or Release/Verification of Hospital Privileges or hospital affiliation letter dated within 180 days

If you are a nurse practitioner, you must have a New York State nurse practitioner collaboration agreement/arrangement/protocol.

MEMBER INFORMATION

Please complete this section and give the form to your doctor. Your doctor will complete the Provider Information section above and submit the form to the Funds.

☐ I want the Funds to contact my doctor listed above so he or she can become an 1199SEIU Participating Provider.

Member's full name ______________________ Member's telephone number ______________________

Institution ______________________

This document is not an application, but a request for participation. It is subject to the Funds' network adequacy guidelines. In order to apply for participation with the Funds, you MUST participate with CAQH. The Funds only accept CAQH participants' applications. Please ensure that you have authorized the Funds to have access to your CAQH data.

FOR INTERNAL USE ONLY

Rep name: ______________________

Manager approval: ______________________