1199SEIU Benefit Funds • www.1199SEIUBenefits.org

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 PHONE* | OFFICE FAX

OFFICE CONTACT* | PROVIDER'S EMAIL ADDRESS*

CREDENTIALING CONTACT* | CREDENTIALING CONTACT'S PHONE

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 attest that my CAQH attestation is within 120 and not older than 180 days. My Malpractice Insurance Certificate and other credentialing items are current in CAQH. I hereby authorize the 1199SEIU Funds to access my CAQH profile.

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

X _____
PROVIDER'S SIGNATURE | DATE

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 PREFERRED PHONE

EMPLOYER NAME

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: _____

Provider ID or Validation Check (initials) _____

Group contract on file ☐ Yes ☐ No