Health Partners Plans

Hospital-based Practitioner Profile

Practitioner Specialty	Board Certified	Board Eligible
❒ **Anesthesiology**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Emergency Medicine**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Neonatology**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Pathology**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Radiology**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Hospitalist**	Yes ❒ No ❒	Yes ❒ No ❒
❒ **Other (please specify)** _______________	Yes ❒ No ❒	Yes ❒ No ❒

Are you pursuing Board Certification in the Specialty for which you are applying? Yes ❒ No ❒

If yes, when is your date planned? ___________________

Hospital Affiliation(s) ____

Do you practice exclusively in the hospital setting? Yes ❒ No ❒

If no, will members be directly referred to this practitioner? Yes ❒ No ❒

Does practitioner practice in an office setting outside of the main hospital? Yes ❒ No ❒

Does practitioner have scheduled office hours for members? Yes ❒ No ❒

Does practitioner practice exclusively within a free standing facility providing care for members only as a result of members being directed to the facility? Yes ❒ No ❒

Practitioner Information

Individual NPI ________________ **Medical License #** ________________

Name ____
(Last Name) (First Name) (Middle) (Title)

Social Security # _____________ Date of Birth ___ / ___ / ____ Gender _______ Ethnicity *(optional)* __________

Medicare # _________________ DEA # _______________ Languages _________________________

Medicaid # _________________ If you do not have a Medicaid #, have you applied for one? Yes ❒ No ❒

If yes, when did you apply? ____________

Internship/Residency

Institution ____ Type of Training _____________________________________

City ___________________________ State _______ Country _______________ Specialty _________________________

Program Completed: Yes ❒ No ❒ Date of Entry ___ / ___ / _____ Date of Completion ___ / ___ / _____

If not completed, please explain ____

Practice Information

Practice Name ____

Practice Address ____

City___________________ State _____ Zip _________ Phone # (___) ______________ Fax # (___) ______________

Practice Information (*continued*)

Office Manager Name ___________________________ Patient Age Range ____________________________________

Credentialing Contact Name _____________________ Phone # (___) _________ E-mail _______________________

Credentialing Contact Address ____

Billing Information

Federal Tax ID Number ___________________ ❐ Check to indicate that W-9 form is attached

Name ____

Address ____

Manager Name ___________________________ Phone # (___) _________ Fax # (___) __________

Group/Vendor NPI ____

Form Completed By: ________________________________ Date: _______________________

Photocopy and complete page 1 only for each additional office associated with the applicant's practice.

I hereby apply to become a **Hospital Based** practitioner in the Health Partners Plans network.

I certify that all of the information that I have submitted in connection with the profile is true, accurate and complete. I understand that Health Partners Plans will rely on this information to evaluate my participation in the prepaid program provided through Health Partners Plans.

I understand that any material misstatement or omission of fact on the application is grounds for summary dismissal from Health Partners Plans as provided in the Provider Agreement.

I attest to having current, valid malpractice insurance coverage in the amount required by the State of Pennsylvania.

I agree to adhere to the code of ethics of the AMA, AOA, or the __________________ (appropriate professional organization of specialty or scope of practice).

I authorize Health Partners Plans and/or its designated provider database coordinator to consult with members of the medical staff, affiliate hospitals, professional liability carriers, and health care facilities with which I have been associated. In addition, this authorization includes consultation with other health care professionals who may have information bearing on my competency, character, physical health status, emotional health status, and ethical aspects of my professional practice. I authorize release of such information to Health Partners Plans and/or its designated credentialing agent upon request. I agree a facsimile or photocopy of my signature will serve the same as the original.

____ ______________________________

Signature of Applicant **Date**

____

Print Name of Applicant

Please mail this profile to:

Health Partners Plans
901 Market Street, Philadelphia, PA 19107
Attn: Provider Database Maintenance

Or fax it to:

215-967-9274

Or email it to:

providerdata@hpplans.com