New York Network IPA, Inc.
New York Network Management, LLC

Section A-APPLICANT RESPONSIBILITY

Applicant Name: ____

To remain in compliance with all insurance carriers via NYNM, kindly forward the documents within five (5) days of receipt of this notification.

PLEASE CHECK:

	☐	NY/NJ State Registration & License
	☐	DEA Certificate
	☐	Malpractice Coverage face sheet (1M-3M)
Page 1	☐	All W-9 Tax ID forms applicable for billing
Page 2	☐	Participation Acknowledgement form (must be signed and returned with application)
Page 3	☐	Attestation and release form (must be signed before returning application)
Page 4	☐	NYS DOH Access and Availability
Pg 5 - 8	☐	NYNM Application
Page 9	☐	Appendix A-1 Certification Regarding Lobbying Act (Addendum to contract)
Page 10	☐	Provider Category Attestation
Page 11	☐	Resident Records and Credentials Affidavit

By submitting an application to NYNM, you are hereby notified that you have the right to the following:

- To review information obtained to evaluate your application
- To correct erroneous information found when verifying information(during re-credentialing)
- To be informed of the application status, upon request

Kindly submit to: Fax number 888-761-8882. If you have any questions you may contact us 718-748-7316.

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

New York Network IPA, Inc.
New York Network Management, LLC

PARTICIPATION ACKNOWLEDGMENT

I, ____________________________, understand that New York Network IPA, Inc. and New York Network Management LLC (collectively, "NYNM") have established a network of physicians who have agreed to provide medical services to covered persons under benefit plans offered by health insurers, health maintenance organizations, prepaid health services plans, self-insured employers and other payors in exchange for reimbursement at negotiated rates.

1. **Current Payor Benefit Plans.** I hereby acknowledge that I have authorized NYNM, through the participation agreements I have executed with New York Network IPA, Inc. and New York Network Management LLC (collectively, "the NYNM Participation Agreements"), to bind me to participate in the Payor Benefit Plans checked below under the terms of such Payors' participation agreements with NYNM (the "NYNM Payor Agreements"). I hereby certify that I have been given the opportunity to review the full terms of the NYNM Payor Agreements, including the attached sample fee schedules. I further acknowledge that my participation under the NYNM Participation Agreements supersedes any other contractual arrangement I may have with respect to the provision of Covered Services to Covered Persons.

PLAN NAME
• Amerigroup
• WellCare Medicare
• WellCare Medicaid (effective 5/1/12)
• Fidelis Care
• Consumer Health Network (CHN)
• Coventry (First Health and Community Care Network (CCN))
• Devon Health Services/Americare
• Evolutions Healthcare* Guardian Resources, Inc
• Galaxy Health Network
• Health Plus (acquired by Amerigroup effective 5/1/12)
• MultiPlan/ Beechstreet/ PHCS (Private Healthcare Systems)/ BCE Emergis G.E.H.A. - United Payors & United Providers
• PPO Next
• EasyChoice (executed, awaiting DOH approval)

2. **Future Payor Benefit Plans.** In addition, I affirm my intent to participate with all additional Payor Benefit Plans that may be offered in the future, except for those I opt out of pursuant to the terms of the relevant NYNM Participation Agreement.

Agreed and accepted on this ___ day of ________________, _________.

By: _______________________________   _____________________________

Physician Signature   Witness

____

Physician Printed Name

New York Network IPA, Inc.
New York Network Management, LLC

ATTESTATION & RELEASE

By applying for credentialing or recredentialing as a participating provider in New York Network Management, I hereby signify my willingness to supply information, appear for an interview, and permit an inspection of my practice office(s) and medical record keeping practices to the extent legally permitted and deemed necessary by New York Network Management in evaluating my application. I hereby authorize and consent to the release of information by any hospital or hospital medical staff, medical associations, managed care entity, National Practitioner Data Bank, State Department of Social Services and State Department of Health, other governmental services, Federation of State Medical Boards, AMA Master file, malpractice insurance carriers, and other entities with which I have been associated or which may have information material to an evaluation of my professional qualifications, competence, character and ethics.

I hereby release from liability, New York Network Management, its staff and agents for their acts performed in good faith in connection with evaluating my application, credentials, and qualifications, and I hereby release from liability, any and all individuals and organizations who provide information or documents to New York Network Management, its staff or agents in good faith concerning my professional qualifications, competence, character and ethics.

In cases where there is a delegated arrangement, I hereby consent to the inspection of any document or information required as stipulated in delegation agreement and applicable law.

By my signature, I hereby attest that the information in this application is complete and correct in all respects, I further understand that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of the contract. I also understand that I have a continuing obligation to notify New York Network Management of any changes in my status as noted on the application.

I am also aware that I may review information received from an outside primary source in support of my application (with the exception of the National Practitioner Data Bank, references, recommendations or other information that is peer review protected), correct erroneous information and inquire about the status of my credentialing application by contacting NYNM in writing.

Photostatic/fax copy of this form will be as valid as the original.

NPI & Taxonomy Codes-Individual & Group (as applicable). Kindly attach a copy of the NPI Enumerator confirmation form(s).

NPI Numbers	Taxonomy Code(s)
Individual:	
Group:	
Email Address:	

Physician Name: (Please Print)	NYS License Number:	Social Security Number:
Signature:		Date Signed:
ANY OTHER NAME POSSIBLE USED IN RECORDS:		

(718) 748-7316
credentialing@nynmonline.com
www.nynmonline.com

New York Network IPA, Inc.
New York Network Management, LLC

Access and Availability Standards

The New York State Department of Health requires that the following Access and Availability Standards be met by Primary Care Physicians,OB/GYNs,and BehavioralHealth Providers where applicable.

Situation	Timeframe
Emergency care	Immediately upon presentation at a service delivery site
Urgent care	Within 24 hours
Non-urgent sick visits	Within 48 - 72 hours as clinically indicated
Routine,non-urgent,or preventive appointments	Within 4 weeks
Specialist referrals (non-urgent)	Within 4 - 6 weeks
Well child care	Within 4 weeks
Initial prenatal visit	Within 2 weeks for the initial visit, every 2 weeks during the second trimester, and every week thereafter
InitialPCP office visit for newborns	Within 2 weeks of hospital discharge
In-plan mental health or substance abuse	Within 5 days, or as clinically indicated
Follow-up visits (pursuant to an emergency or hospital discharge)	Within 1 week
Adult baseline and routine physicals	Within 12 weeks from enrollment (adults >21 years)
Non-urgent mental or substance abuse visits with a PCP	Within 2 weeks

The standard for returning a member call is 30 minutes. It is not acceptable to have an answering machine in place that does not connect directly to the provider. The message must direct the member to a live voice.The primary care provider is responsible for arranging on-call and after hours coverage to ensure 24-hour telephone access to all members.

Members with appointments should not be made to wait longer than minutes. Walk-in members with urgent needs should be seen within one hour,and walk-in members with non-urgent needs should be seen within two hours,or scheduled for an appointment consistent with the above scheduling guidelines.

ACKNOWLEGEMENT STATEMENT

I,_________________________________is hereby informing New York Network Management, LLC (collectively,"NYNM") that I am in receipt of the State Medicaid Manage Care standards. I am further acknowledging that I have been properly educated by NYNM, and will transfer all information regarding this participation to my staff.

Acknowledged by: x____,

On this ______________, day of _______________________, in the year ___________,

Witnessed by: ____.

New York Network IPA, Inc.
New York Network Management, LLC

Re-Credentialing Application

Section 1 - Provider Information

Provider Last Name: ________________________ Provider First Name: ________________________________

M.I: _____Degree: ________ M/F_____ Date of Birth: __________________ S.S. #: _____________________

Practice Category: PCP ☐ Specialist ☐ Both ☐

Medicaid #: __________ Medicare #: _________________ NPI #: ______________________

NPI - Related Taxonomy Codes: _____________________________________

CAQH #: ____ E-mail: ____________________________________

Number of FTE Physicians Extenders Used in Office: _________

Wheelchair Access (Y/N): ____

Primary Specialty:	Board Status (Certified/Eligible):	Exp. Date:
Secondary Specialty:	Board Status (Certified/Eligible):	Exp. Date:
Primary Hospital:	Secondary Hospital:	Others:

Section 2 - Practice Information *(Please attach additional sheets for other locations.)*

Primary Office	**Secondary Office**	**Alternate Office**
Type of Practice: Group ☐ Solo ☐	Type of Practice: Group ☐ Solo ☐	Type of Practice: Group ☐ Solo ☐
Practice Name (if any):	Practice Name (if any):	Practice Name (if any):
Address:	Address:	Address:
City:	City:	City:
State: Zip:	State: Zip:	State: Zip:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:

Re-Credentialing Application

Section 2 - continued *(Please attach additional sheets for other locations.)*

Primary Office Hours	Secondary Office Hours	Alternate Office Hours
Mon: to:	Mon: to:	Mon: to:
Tues: to:	Tues: to:	Tues: to:
Wed: to:	Wed: to:	Wed: to:
Thurs: to:	Thurs: to:	Thurs: to:
Fri: to:	Fri: to:	Fri: to:
Sat: to:	Sat: to:	Sat: to:
Sun: to:	Sun: to:	Sun: to:
App’t Tel:	App’t Tel:	App’t Tel:
App’t Fax:	App’t Fax:	App’t Fax:

Section 3 - Billing

Primary Office Billing Info (please attach W9 forms)	Secondary Office Billing Info	Alternate Office Billing Info
Payee Name:	Payee Name:	Payee Name:
Remittance Address:	Remittance Address:	Remittance Address:
City:	City:	City:
State: Zip:	State: Zip:	State: Zip:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Tax ID:	Tax ID:	Tax ID:

Section 4 - Malpractice Insurance Information

Provider Name: ____________________________________ Provider Signature: ___________________________
(Please enclose a copy of your current Certificate of Insurance.)

Professional Liability Carrier: ___________________________________ Expiration Date: ________________

If covered by a Clinic/Group, please provide name: ____

Re-Credentialing Application

Section 5 Malpractice Insurance Information

IF YOU ANSWER "YES" TO ANY QUESTION BELOW, PLEASE PROVIDE A FULL EXPLANATION ON THE NEXT PAGE.

Since your previous credentialing, have you:

#	Question	Yes/No
1.	Had your license to practice in any jurisdiction been denied, restricted, and limited, suspended (even if suspension was stayed) or revoked, either voluntarily or involuntarily?	
2.	Been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice?	
3.	Had your DEA or state controlled substances registration been restricted, limited, suspended, (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	
4.	Been denied hospital privileges or have your hospital privileges revoked, suspended (even if the suspension was stayed), reduced or non renewed?	
5.	Voluntarily relinquished or voluntarily limited any hospital privileges?	
6.	Any disciplinary proceedings been instituted against you or any disciplinary actions now pending with respect to your hospital privileges or your license?	
7.	Been denied participation in Medicare, Medicaid or any other governmental or quasi-governmental health-related program?	
8.	Been reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participating in Medicare, Medicaid or any other governmental or quasi-governmental health-related program?	
9.	Been asked to resign, withdraw or terminate your position with a medical partnership, professional association, HMO, medical practice, either public or private?	
10.	Any complaints filed against you with any medical society or licensing authority?	
11.	Any professional liability cases currently pending?	
12.	Any professional liability settlements/judgments been made against you?	
13	Been denied professional liability insurance?	
14.	Been convicted of a crime (other than a minor traffic offense) or do you have any criminal charges pending other than for minor traffic offenses?	
15.	Been refused participation in an HMO or PPO network or been disciplined by or terminated from such a plan or participation?	
16.	A current physical or mental health impairment (or any other inability) that would prevent you from performing the essential functions within your scope of practice, with or without accommodation?	
17.	Been using or are currently using illegal drugs or controlled or dangerous substances?	

Re-Credentialing Application

Malpractice Explanation Notes

____
____
____
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____
____

Signature: ______________________________ Date: ____________________

Personal Information

Provider Home Address:

______________________________ Home Phone: ______________________________

City: __________________________ Cell Phone: ______________________________

State: _______ Zip: _____________

APPENDIX A-1
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DATE:_____________________________

TITLE: ____

ORGANIZATION: ____

NAME: (Please Print) ____

SIGNATURE: ____

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New York Network IPA, Inc.
New York Network Management, LLC

Provider Category Attestation

*****CORRECT INFORMATION REQUIRED*****
Information received on this form will directly correspond to how you are loaded with the plans/payers. Incorrect information can adversely affect your claims processing and payments and may result in claims denials.
*****Please complete carefully.*****

Provider Last Name: ___________________________ First Name: ______________________________

Provider Degree: ______________________________

Provider Category
Primary Care Provider ☐ Specialist Provider ☐ Dual Provider ☐ Allied Health Provider ☐

Provider Specialty
Primary Practicing: ____

Secondary Practicing: ____

Provider Attestation of Specialty:

I, ______________________________________, attest that I wish to be listed as the provider type indicated below:

______ I am a Specialist Provider. I attest that I understand that I am not practicing as a Primary Care Provider even if I am trained or board certified in a Primary Care Provider designated specialty.

______ I am a Primary Care Provider. I attest that I may be assigned a patient panel and may be chosen by plan members as their Primary Care Provider. I attest that I understand that I am not practicing as a Specialist Provider even if I am trained or board certified in a Specialist designated specialty.

______ I am a Dual Practice Provider. I attest that I am a Primary Care Provider and as such, I may have a patient panel assigned to me or I may be chosen by a plan member as their Primary Care Provider. I further attest that I am also a Specialist Provider and may have referrals made to me in my chosen specialty.

______ I am an Allied Health Provider. I attest that I am neither, a Primary Care or Specialist Physician Provider.

Provider Signature: ____ Date:_________________________

Provider Printed Name: ____

Provider NPI: ____

(718) 748-7316
credentialing@nynmonline.com
www.nynmonline.com

Resident Records and Credentials
Affidavit and Authorization for Release of Information

I, the undersigned, hereby certify under oath that I am the person named below, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named on this form and credentials furnished or to be furnished with respect to my request and that all documents, forms or copies thereof furnished or to be furnished with respect to my request are strictly true in every aspect.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind.

I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

____
Physician's Printed Name

____________________________________ ____________________
Physician's Signature Date of Signature

____
Resident Program Physician Attended

Please forward the information to:

____
Company and/or Individual's Name

____
Address Line 1

____
Address Line 2

____
City State Zip Code

Fax this completed form to (817) 868-5099 or mail to:
FCVS/ P.O. Box 619850/ Dallas, TX 75261