1199SEIU Benefit Funds

498 Seventh Avenue, 7th Floor, New York, NY 10018-0009 • Tel: (646) 473-7160 • Fax: (646) 473-7229 • www.1199SEIUBenefits.org • @1199SEIUBenefitFunds

PROVIDER RECRUITMENT FORM (REQUEST FOR PARTICIPATION)

Please complete the entire form to avoid delays.

This form is a request to participate in the Benefit Funds' network. Submitting this form is not a guarantee of acceptance into the network. Participation is subject to, among other conditions, the Benefit Funds' network adequacy guidelines. The Benefit Funds evaluate the current need to service our membership in your area. Network need evaluation is a separate process from credentialing.

Please note that to participate in the Benefit Funds' network, you MUST be registered with the Council for Affordable Quality Healthcare (CAQH). The Benefit Funds accept only CAQH-registered providers. If the Benefit Funds decide to invite you to participate, the Benefit Funds will review your CAQH data, so please ensure that you have authorized the Benefit Funds to access this data.

PROVIDER INFORMATION

For faster processing, please complete this form online and fax to (646) 473-7213 or email to Providers@1199Funds.org. Allow up to 45 days from receipt for processing.

☐ Please send me information on becoming an 1199SEIU participating provider. _____ DATE (MM/DD/YYYY)

All fields marked with an asterisk (*) are required

*PROVIDER'S LEGAL NAME

*DATE OF BIRTH (MM/DD/YYYY) (for secondary validation) *GENDER

*ETHNICITY [Select One]

*PROVIDER'S SECONDARY LANGUAGE(S) [Select One]

*GROUP/PRACTICE NAME

*TAX ID #

*PRIMARY SERVICE LOCATION

*CITY *STATE *ZIP CODE

*OFFICE PHONE

OFFICE FAX

*OFFICE CONTACT

*WEBSITE ADDRESS (if applicable)

*PROVIDER'S EMAIL ADDRESS (for official Provider Notice)

*PATIENT-FACING EMAIL (if different)

*CREDENTIALING CONTACT NAME

*CREDENTIALING CONTACT EMAIL ADDRESS

*CREDENTIALING CONTACT PHONE NUMBER

*BEST METHOD OF CONTACT FOR QUESTIONS AND TO RECEIVE COMMUNICATIONS FROM THE BENEFIT FUNDS

*PRIMARY SPECIALTY (applying as)

*SECONDARY SPECIALTY (applying as, if applicable)

*BOARD CERTIFIED ☐ Yes ☐ No

If no, do you plan to take the boards? ☐ Yes ☐ No

*INDIVIDUAL NATIONAL PROVIDER IDENTIFIER (NPI)—MUST BE 10 DIGITS

HOSPITAL AFFILIATION (primary admitting hospital, if applicable)

*CAQH ID #

(continued on next page)

☐ * I attest that my CAQH attestation is within 90 days and not older than 120 days. My malpractice insurance certificate and other credentialing items are current in CAQH.

☐ * I attest that I have authorized the 1199SEIU Benefit Funds to access my CAQH profile.

*If you are a nurse practitioner, do you have a:

New York State nurse practitioner collaboration agreement? ☐ Yes ☐ No

New York State collaborative arrangement/protocol? ☐ Yes ☐ No

You will receive written notification once request for participation has been evaluated.

X_____

PROVIDER'S SIGNATURE DATE (MM/DD/YYYY)

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 Benefit Funds.

☐ I want the Benefit Funds to contact my doctor listed above so that he/she can become an 1199SEIU participating provider.

_____

MEMBER'S FULL NAME (FIRST AND LAST) MEMBER'S PREFERRED PHONE NUMBER

_____

EMPLOYER'S NAME

FOR INTERNAL USE ONLY

For Network Management Unit:

Rep. name: _____ Manager approval: _____ Date sent to credentialing: _____

Provider ID or validation check (initials) _____ Group contract on file ☐ Yes ☐ No Practitioner/other agreement attached: ☐ Yes ☐ No

For NPs:

Collaborative agreement attached ☐ Yes ☐ No Collaborative arrangement/protocol ☐ Yes ☐ No

For Credentialing Unit:

Date received: _____ Date assigned: _____ Credentialing specialist: _____