PROVIDER DATA COLLECTION FORM

CAQH ID		**Provider Name**	
Individual NPI		**Group NPI**	
Address (complete)			
Birth Date		**Phone #**	
Applying as a (circle one)	PCP Specialist PCP/Specialist CRNP/PA Allied Health		
Ethnicity		**Medicaid Number**	
VFC ID / PIN # (Participation in VFC is required for all PCPs servicing members 0 – 18 years old)			
Laboratory Used (check one) You must select either Quest or one of the hospitals listed. If no selection, Quest will be assigned.	☐ Quest ☐ Hospital (circle one) AEMC Aria Hahnemann HUP St. Chris Temple		
License Number			
Practicing Specialty for Directory			

Attestation Statement and Authorization to Release Information

I hereby apply to become a (circle one) **Primary Care** or **Specialist** practitioner in the Health Partners network.

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

I understand and agree that I am to adhere to and abide by the terms and conditions of this program(s) and any and all Agreements I have or will in the future enter into with Health Partners.

I understand that any material misstatement or omission of fact on the application is grounds for action by Health Partners, including but not limited to summary dismissal from Health Partners as provided in the Provider Agreement.

I attest to having in the amounts required by the State of Pennsylvania current, valid malpractice insurance coverage and all other applicable professional insurances.

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 and/or its designated credentialing agent to consult with members of the medical staff, affiliate hospitals, professional liability carriers, and healthcare facilities with which I have been associated. In addition, this authorization includes consultation with other healthcare 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 and/or its designated credentialing agent upon request. I agree a facsimile or photocopy of my signature will serve the same as the original.

I attest that I have clinical admitting privileges at the Health Partners participating hospital noted on my CAQH or PA Standard application.

___________________________________   _____________
Signature of Applicant   Date

____
Print Name of Applicant

NOTE: Please include signed and dated Health Partners agreement or an updated Exhibit C for your existing group agreement.

CR2011-001