Application for Non-Physician Health Care Practitioner

This application is only used for participation with CDPHP Copies of your licenses, malpractice (liability) insurance, and W-9 must be attached. Enrollment will not be processed without this documentation.

All fields must be completed.

Requested Effective Date:				
Request type:	☐ First-time application	☐ Join a new tax ID	☐ Demographic change	☐ Sponsor change
Applying as:	☐ Nurse Practitioner	☐ Physician Assistant	☐ Registered Nurse First Assistant	
☐ Certified Behavior Analyst Assistant	☐ Licensed Master Social Worker (LMSW)	☐ Licensed Creative Arts Therapist (LCAT)	☐ Psychoanalyst	

Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender: ☐ Female ☐ Male	
Social Security #:	Individual NPI #:	CAQH Provider ID:
Non-Physician Taxonomy Code:	Specialty:	
License #:	License State:	
DEA Certification #:	DEA Certification State:	
Medicare #:	Medicaid #:	
To be enrolled in Medicare products, an active Medicare ID is required (does not apply to Psychoanalysts, LMSW or LCAT).	To be enrolled in Medicaid products, an active Medicaid ID is required (does not apply to Psychoanalysts, LMSW or LCAT).	

What language(s) are you fluent in when speaking about medical care? *Check all that apply.*

☐ Arabic	☐ ASL	☐ English	☐ French
☐ Mandarin	☐ Nepali	☐ Russian	☐ Somali
☐ Spanish	☐ Ukrainian	☐ Vietnamese	☐ Other:

What language services are available at your location? *Check all that apply.*

☐ Bi-Lingual Staff	☐ On Site Interpreter
☐ Remote Interpreter - Audio	☐ Remote Interpreter - Video

Race - *to be shared with members upon request*

☐ American Indian or Alaskan Native	☐ Other
☐ Asian	☐ Prefer Not to Say
☐ Black or African American	☐ White
☐ Native Hawaiian or other Pacific Island	

Ethnicity - *to be shared with members upon request*

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Say

☐ "I attest that I have completed 3,600 hours of experience as a licensed or certified NP 1-in accordance with the laws of New York or another state or 2-while employed by the United States veteran's administration, armed forces or public health service. Therefore, I do not require a collaborating provider."

If yes, please leave the Collaborating Physician fields blank but include Group Name, Group NPI, Group Tax ID and Specialty.

Collaborating Physician Name:	
Collaborating Physician NPI #:	
Group Name:	Group NPI #:
Tax ID #:	Specialty:

Office addresses must be identified by street level information with the corresponding City, State and ZIP Code. PO BOX information is not allowed. Please provide only ONE Correspondence, ONE Remittance, and ONE Medical Records address. Each address can be the same or different, but must be identified as a valid United States Postal Service mailing address. If PO BOX information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided and no street level information present.

Primary Address:			Ste:
City:	State:	Zip Code:	
Phone:		Fax:	
Is this address used for "Telehealth services." ☐ Yes ☐ No		Is this address Handicap accessible? ☐ Yes ☐ No	

Additional Address:			Ste:
City:	State:	Zip Code:	
Phone:		Fax:	
Is this address used for "Telehealth services." ☐ Yes ☐ No		Is this address Handicap accessible? ☐ Yes ☐ No	

Correspondence Address:			Ste:
City:	State:	Zip Code:	
Phone:		Fax:	

Medical Record Address:			Ste:
City:	State:	Zip Code:	
Phone:		Fax:	

Remittance Address:			Ste:
City:	State:	Zip Code:	
Phone:		Fax:	

APPLICATION ATTESTATION: I, the undersigned, hereby attest that the above information is true and accurate to the best of my knowledge. By signing this application, I attest to not providing Telehealth only services and understand that I must maintain a physical practice location within the Health Plan's geographic service area to be considered for an in network participation.

Applicant Name (signature):	Date:

COLLABORATING PHYSICIAN ATTESTATION: I, the undersigned, hereby verify and attest that I am the collaborating physician for the above-named applicant. As required by applicable laws, I have satisfied myself as to the ability and competency of this applicant and that the functions that the applicant will carry out are performed under my collaboration and oversight.

Collaborating Physician Name (print):	Date:
Collaborating Physician Name (signature):	
Office Contact Name & Phone:	
Office Contact Email:	

Submit the completed application, diploma, licenses, malpractice (liability) insurance and W9 to us using one of the methods below. Psychoanalysts, LMSWs and LCATs must also include a copy of the collaborating physician's license.

Email: provider.enrollment@cdphp.com

Fax: (518) 641-3209