Clear Form

MetroPlusHealth

Provider Information Form

MetroPlus Health Plan, Inc. utilizes the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. This service is free for physicians and other health care professionals. This service eliminates redundancies in completing credentialing applications for multiple health plans, eliminates the need to print and mail credentialing applications, minimizes paperwork by allowing physicians and other health care providers to make updates online, and enables physicians and other health care professionals to easily access their information.

To begin your credentialing process, please complete this form. All requested information is required. **Please print clearly** and send your **completed form and current resume** to the Credentialing Department via email at: **CREDENTIALING@metroplus.org.** If you wish to participate with MetroPlusHealth at more than one (1) location, complete this form for each additional practice location. Additional information for all sites (to be credentialed/contracted) must be reflected on the CAQH application.

Date Completed: _____ **CAQH ID #:** _____

Provider Information		
Last Name:	**First Name:**	**Degree:**
License #:	**Individual NPI Number:**	**Email Address:**

Is the applicant a newly licensed physician? ☐ Yes ☐ No *If yes, provide date of licensure:* _____

Is the applicant a physician relocating to NYS without previously practicing in NYS? ☐ Yes ☐ No

Does the applicant offer Telehealth services? ☐ Yes ☐ No Telehealth Only ☐ Yes ☐ No

Specialty: *(List specialty/specialties)*	**Limitations**: *(For Family Practitioners, note limitations)* Age range for the patients that the provider treats
Languages: *(List languages spoken by the provider)* **American Sign Language (ASL)** ☐ Yes ☐ No	**Does your office have a skilled medical interpreter?** ☐ Yes ☐ No *If yes, list languages interpreted*
Employer: _____ Print Name of Practice/Facility **Check the facility type below:** ☐ Diagnostic & Treatment Center (Article 28) ☐ Article 31 licensed facility ☐ Article 16 licensed facility ☐ 3D Kids IPA	**If Dietetics/Nutrition specialist:** Are you a certified diabetes educator? ☐ Yes ☐ No **Certification #:** _____ Do you have "certified registered dietician" certification by the Commission on Dietetic Registration? ☐ Yes ☐ No **Certification #:** _____

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Date Completed: _____ **CAQH ID #:** _____

Primary Practice Information			
Tax ID (TIN): *(Attach W9)*	**Email Address:** *(To be printed in the directory)*		
Address: *(Include Floor/Suite#)*	**City:**	**State:** New York	**Zip Code:**
Appointment Phone #:	**After-Hours Access Phone #:**	**Fax Number:**	
Credentialing Agent Information			
Name:	**Phone:**	**Email:**	
Comments			