MOUNT SINAI HEALTH PARTNERS IPA, LLC

PROVIDER APPLICATION FORM

All providers affiliated with Mount Sinai Beth Israel, Mount Sinai Brooklyn, Mount Sinai Morningside, Mount Sinai West, Mount Sinai St. Luke's, The Mount Sinai Hospital, Mount Sinai Queens, and New York Eye and Ear Infirmary of Mount Sinai and Mount Sinai South Nassau are invited to complete this Provider Application Form for membership in the Mount Sinai Health Partners (MSHP) network.

Applicants are requested to thoroughly complete the following 7 Steps:

1. ☐ Review the Participating Provider Agreement (in its entirety)

A. Please sign the signature page of the Participating Provider Agreement (page 17 and 18 of the Agreement or**, for your convenience, the signature page is also attached to this Provider Application Form**).

B. Please sign the Certification Regarding Lobbying page in the Participating Provider Agreement (page 31 of the Agreement or**, for your convenience, the signature page is also attached to this Provider Application Form**).

2. ☐ Does any physician in your group applying for MSHP membership provide clinical services with more than one organization and bill for services with more than one tax ID? (please check one of the following; if yes, please list TINs separately)

☐ YES ☐ NO

3. ☐ Attach completed W-9 Form per associated TINs

4. ☐ Declaration Forms

5. ☐ MSHP annual membership dues: **$315** for each PCP, **$315** for each Specialist, **$315** for each Behavioral Health or Non-MD/DO provider, **$2,100** for each FQHC and **$525** per FQHC location. **Pay online with your credit card**: **https:// mshp.mountsinai.org/web/mshp/paydues**.

6. ☐ To facilitate my registration as an MSHP member into the secure database, I ( ) hereby authorize Mount Sinai Health System (MSHS) Medical Staff Offices and Managed Care Contracting departments to share provider registration information with Mount Sinai Health Partners IPA, LLC.

7. ☐ Please complete the following information:

A. Individual Name

- Last Name_____First Name_____Middle Initial_____
- Primary Specialty:_____Secondary Specialty: _____
- What is the provider to be listed as, Primary Care, Specialists or Mid-level? _____
  Mid-levels are defined as Nurse Practitioner, Physician Assistants, and Certified Nurse Mid-Wives.
- If physician is a "Primary Care Physician," does the physician also provide specialist services and wants to be listed as a "Dual" provider. I.e., PCP/Specialist._____Yes _____No

Board Certification

Are you board certified in your practicing specialty? ☐ Yes ☐ No

If not, please explain: _____

List the board-certified board and your expiration date of board status:

_____

If not boarded, you must be Board Eligible. What is the expiration date of your eligibility? (Typically 5 years from post highest level of training).

_____

Please note, if you are not boarded or board eligible, you are not eligible for membership to the MSHP IPA.

Hospital Affiliation(s):

☐ MSBI ☐ MSM ☐ MSH ☐ NYEEIMS

☐ MSB ☐ MSW ☐ MSQ ☐ MSSN

Type of Privileges

☐ Full Admitting Privileges ☐ Limited Admitting Privileges

☐ Non-admitting ☐ Other _____

All MSHP physicians applicants must have active admitting privileges at a Mount Sinai Health System hospital and affiliates. i.e., MD/DO/DPM. If you do not have please send us a personal explanation how you admit patients if needed.

Degree _____

B. Tax Identification Number:
(Please include a copy of your W9 Form, for each TIN submitted with your completed application)

Check appropriate box:

☐ **Individual TIN** (if applying as an individual): _____

☐ **Group TIN #1** (if applying as a group): _____

☐ **Group NPI:** _____

***(Group NPI** is required. If you do not have one, please explain)*

☐ **Billing Name:** _____

☐ **Billing Address:**

Street: _____

City/State/Zip: _____

C. National Provider Identifier:

- **Individual NPI:** _____
- **Taxonomy Code:** _____

D. Individual State License Number#: _____

E. DEA Certificate #: _____

If you do not have an active DEA Certificate, please explain why:

_____

F. Do you accept Medicare Patients? ☐ Yes ☐ No

Individual Medicare#: _____

G. Do you accept Medicaid Patients? ☐ Yes ☐ No

Individual Medicaid#: _____

H. CAQH ID #: _____

(Please make sure to Authorize MSHP for access to CAQH data and CAQH application in a valid status (i.e., attestation or re-attestation).

I. Individual Email: _____

Continues on next page

Office Location: ***If provider is PCP, office hours are required and there must be 16 hours minimum at each location. Practitioner needs to be working from the location. They can't be listed for more than 10 locations.***

I. **Primary Office Information:** **(Please provide additional addresses if applicable.)**

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Secondary Office Information: **(Please provide additional addresses if applicable.)**

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Third Office Information: **(Please provide additional addresses if applicable.)**

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

☐ **Group TIN #2** (if applicable)**:** _____

☐ **Group NPI:** _____
***(Group NPI** is required. If you do not have one, please explain)*

☐ **Billing Name:** _____

J. Primary Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Secondary Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Third Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

☐ **Group TIN #3** (if applicable)**:** _____

☐ **Group NPI:** _____
***(Group NPI** is required. If you do not have one, please explain)*

☐ **Billing Name:** _____

K. Primary Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Secondary Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

Third Office Information: (Please provide additional addresses if applicable.)

Show in Directory? ☐ Yes ☐ No

Street: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Office E-Mail: _____

Office Hours: _____

TIN: _____

L. Correspondence with MSHP:

Telephone: _____

E-mail: _____

Fax: _____

Cell: _____

Primary Contact(s): _____

M. Does your practice/group use an Electronic Health Record System?

☐ **YES** ☐ **NO**

If yes, please indicate "Vendor Name/Service Organization", software/product version and answer the 3 EMR questions below.

_____

1. **Do you have remote access capability?** Remote access is the ability for an authorized person to access your EMR from a location other than your practice location.

☐ **YES** ☐ **NO** ☐ **I DON'T KNOW**

2. **Will you grant MSHP remote access capability?** Remote access is the ability for an authorized person to access your EMR from a location other than your practice location.

☐ **YES** ☐ **NO**

3. **What are the barriers and/or limitations to providing MSHP with remote access to your EMR?**

_____

N. Does your practice/group utilize e-prescribing?

☐ **YES** ☐ **NO**

If yes, please indicate "Vendor Name/Service Organization" and software/product version

_____

O. ☐ **As a new member of Mount Sinai Health Partners IPA, I attest that I am fully educated to bill my claims using a HCFA 1500, have the ability to submit claims electronically, and will stay informed regarding claims submissions to health plans.**

Please email this application to

MSHPCredapp@mountsinai.org

Upon receipt of the completed materials, MSHP will return a fully executed copy of the Participating Provider Agreement to you for your records.

For more information, please contact:

MSHP@mountsinai.org

877.234.6667

[Copy of Signature Page of Participating Provider Agreement]

IN WITNESS WHEREOF, the undersigned authorized signatories of the parties have executed this Agreement as of the date first set forth above.

MOUNT SINAI HEALTH PARTNERS IPA, LLC

By: _____
Signature

Brent Estes
Print Name

SVP and Chief Managed Care Officer
Title

MSHP TWO, LLC

By: _____
Signature

Brent Estes
Print Name

SVP and Chief Managed Care Officer
Title

PROVIDER

By: _____
Signature

_____
Print Name

_____
Title

[Copy of Signature Page of Participating Provider Agreement]

_____

Group Name

_____

TIN#:

[Copy of Lobbying Signature Page of Participating Provider Agreement]

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: _____