MOUNT SINAI HEALTH PARTNERS IPA, LLC

PROVIDER APPLICATION FORM

All providers associated with Mount Sinai Beth Israel, Mount Sinai Brooklyn, Mount Sinai St. Luke’s, Mount Sinai West (formerly MS Roosevelt), The Mount Sinai Hospital, Mount Sinai Queens, and New York Eye and Ear Infirmary of Mount Sinai 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 8 Steps:


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.  □ Print and sign the signature page of the Participating Provider Agreement (page 20 of the Agreement or, for your convenience, the signature page is also attached to this Provider Application Form).

4.  □ Print and sign the Certification Regarding Lobbying page attached, for your convenience, to this Provider Application Form.

5.  □ Write a check paying the first year MSHP annual membership dues of $250.00 for each physician in your group listed below. For example, if your group has 4 physicians who are applying for membership in MSHP, the check will be for $1000. Make check payable to: “Mount Sinai Health Partners IPA, LLC”

6.  □ Please indicate agreement to the following sentence by writing your initials here: _____

   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 or Group Name (1 of the following)

   • Last Name_________________________ First Name_________________________ Middle Initial_______

   • Primary Specialty: ____________________ Secondary Specialty: ____________________

   • If physician is a “specialist”, does the physician also provide primary care services and would be willing to be listed in a directory as a primary care physician? _____ Yes _____ No
OR

- Group Name (if applying as Group):____________________________________________

Hospital Affiliation(s):  ____MSBI     ____MSBIB    ____ MSSL     ____MSW    ____NYEEIMS
____MSH      ____MSHQ

Note: All MSHP applicants must have staff privileges at a Mount Sinai Health System hospital.

B. Tax Identification Number (One of the following)
(Please include a copy of your W9 Form with your completed application)

- Individual TIN (if applying as an individual)_______________________________
- Group TIN (if applying as a group) ________________________________
- Billing Name____________________
- Billing Address____________________

C. National Provider Identifier (One of the following)

- Individual NPI (if applying as an individual)_______________________________
- Group NPI (if applying as a group; see “L”) _______________________________

D. Individual State License Number (if applying as an individual): _________________

E. Individual Medicare #: _______________________________

F. Individual Medicaid #: _______________________________

G. CAQH ID#: _______________________________

H. Primary Office Information:

  Street: ______________________________________________________
  City/State/Zip: _________________________________________________
  Phone: _________________________
  Fax: _______________________
  E-Mail: _____________________
Secondary Office Information: (Please provide additional addresses if applicable.)

Street: ____________________________________________________
City/State/Zip: ______________________________________________
Phone: _________________________
Fax: ______________________
E-Mail: _________________________

I. Correspondence with MSHP:

Telephone: ________________________________________
E-mail:  ___________________________________________
Fax: _____________________________________________
Cell: _____________________________________________
Primary Contact(s): _________________________________

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

[ ] YES  [ ] NO

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

__________________________________________

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

[ ] YES  [ ] NO

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

__________________________________________
L. IF APPLYING AS A GROUP: Complete for each physician in your Group who is applying to be a Participating Provider in the Mount Sinai Health Partners network (attach separate spreadsheet, if needed, to include all names):

Last Name ___________________________  First Name ______________  Initial: ______
Title (MD, DO, DPM): ____________  MSHS Hospital Privileges (List): __________________
New York License: _________________  Individual NPI ________________________
Primary Specialty: _____________________  Secondary Specialty ____________________

If a specialist, does this physician also provide primary care services and would he/she also be listed in a directory as a primary care physician?  _____ Yes      _____ No.

Last Name ___________________________  First Name ______________  Initial: ______
Title (MD, DO, DPM): ____________  MSHS Hospital Privileges (List): __________________
New York License: _________________  Individual NPI ________________________
Primary Specialty: _____________________  Secondary Specialty ____________________

If a specialist, does this physician also provide primary care services and would he/she also be listed in a directory as a primary care physician?  _____ Yes      _____ No.

Last Name ___________________________  First Name ______________  Initial: ______
Title (MD, DO, DPM): ____________  MSHS Hospital Privileges (List): __________________
New York License: _________________  Individual NPI ________________________
Primary Specialty: _____________________  Secondary Specialty ____________________

If a specialist, does this physician also provide primary care services and would he/she also be listed in a directory as a primary care physician?  _____ Yes      _____ No.

Last Name ___________________________  First Name ______________  Initial: ______
Title (MD, DO, DPM): ____________  MSHS Hospital Privileges (List): __________________
New York License: _________________  Individual NPI ________________________
Primary Specialty: _____________________  Secondary Specialty ____________________

If a specialist, does this physician also provide primary care services and would he/she also be listed in a directory as a primary care physician?  _____ Yes      _____ No.
Please submit the following: 1) the completed Provider Application Form, 2) the executed signature page of the Participating Provider Agreement, 3) the signed Certification Regarding Lobbying form, 4) your completed W9 Form, and 5) a check paying the first year IPA annual membership dues of $250.00 for each physician in your group applying for membership in MSHP. Make check payable to: “Mount Sinai Health Partners IPA, LLC”

Please mail completed forms and payment to:

- Mount Sinai Health Partners, 150 East 42nd Street, 5th Floor, New York, NY 10017

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

*To facilitate faster and more efficient communications with members of MSHP, we ask that you provide your E-mail address. Please be assured that your e-mail address will be used strictly for internal communications. We will not share your E-mail address with any outside source.

Preferred e-mail address: ____________________________________________

For more information, please contact:

MSHP@mountsinai.org

877.234.6667
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

Edward Lucy
Print Name

Chief Administrative and Contracting Officer, Mount Sinai Health Partners
Title

PROVIDER

By: ________________________________
   Signature

______________________________
Print Name

______________________________
Title

______________________________
Group Name

TIN#: 

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: __________________________________________