Affinity Health Plan
Dedicated to Excellence

Participation Request / CAQH Form

Date: _____

Complete the Participation Request form and fax to our office at **718-794-7808** for evaluation for participation into the Affinity Health Plan Provider Network. Once your request is reviewed for network need you will be notified either by mail or by an Affinity Health Plan Provider Relations Representative.

(***Please print clearly***)

Provider Last Name _____ **First** _____ **MI** _____ **Degree** _____

Date of Birth _____ **Gender** ( )M ( )F

NYS Lic # _____ **TIN #** _____

Contract Type (Check all that apply): ○ **Group** **NPI Number**_____
○ **Individual** **NPI Number**_____

-○ I am currently a Medicaid provider
MMIS#_____

○ I am not currently a Medicaid provider.
MEDS#_____

-○ I am currently a Medicare provider
Medicare#_____

○ I have opted out of the Medicare program

Requesting participation as a: ○ PCP ○ Specialist ○ Both **Age range accepted**: _____

Specialty _____ **Board Certified?** **Y/ N**

Subspecialty _____ **Board Certified ?** **Y/N**

Name of Facility: _____

Practice Location(s):

1. _____
(incl. Suite #, City, County, State, Zip Code)
2. _____
(incl. Suite #, City, County, State, Zip Code)

Phone: ( ) _____ - _____ **Facsimile:** ( ) _____ - _____ **Email:** _____

Office hours: M: _____ T: _____ W: _____ Th: _____ Fri: _____ S: _____ S: _____
(All Primary Care Providers must have a minimum of 16 hours at each practice site listed.)

Languages Spoken by Provider: _____

Hospital privileges: 1. _____ 2._____

If accepted, you will be required to submit a credentialing application or apply through the Council for Affordable Quality Healthcare **(CAQH)**. Please ensure that you grant Affinity Health Plan access to your CAQH records. If you are not participating with CAQH, you may go to the CAQH website: http://caqh.org/credapp to complete an application. You are required to submit a current copy of your **W-9, Hospital Affiliation Letter, updated curriculum vitae (CV) and Board Certification** with this form.

Are you registered with CAQH? ☐ Yes ☐ No	**If yes, CAQH Provider ID:**

For Affinity Office Use Only:

Reviewed by:_____ Date: _____