QUEEN'S CLINICALLY INTEGRATED PHYSICIAN NETWORK

NEW MEMBER APPLICATION

Please complete ALL fields (write "N/A" if not applicable).	
Date	
Office Phone #	
Fax Phone #	
Provider First Name	
Provider Last Name	
Practice (Front Facing) Name	
Group Name	
Legal Business Name (LBN)	
Primary Practice Address	
Primary Practice City	
Primary Practice Zip Code	
Practice Island	
Secondary Practice Location Street (if applicable)	
Secondary Practice Location City (if applicable)	
Secondary Practice Location Zip (if applicable)	
Provider Email	
Practice Email (if applicable)	
Office Manager or Key Administrative Contact	
Manager or Admin's Phone #	
Manager or Admin's Email	
NPI # - Type 1 (Individual)	
NPI # - Type 2 (Group)	
Specialty - Primary	
Specialty - Secondary (if applicable)	
Signer (contract will be sent to this person)	
Signer's Email (contract will be emailed here)	
What EMR do you use?	
PO Affiliation (if any)	

Email application to QCIPN@queens.org
Questions? Contact us. Call: 808-691-7220 | Email: QCIPN@queens.org

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Please complete ALL fields (write "N/A" if not applicable).				
Do you participate in Primacy Care First?			**Y/N**	
Are you HMSA Contracted?	**Y/N**		**HMSA Provider #**	
Do you participate in HMSA Payment Transformation?			**Y/N**	
If yes, please attach Coreo screenshot of your PCP Performance Measure Dashboard & HMSA Panel				
If not, are you interested in participating?			**Y/N**	
Do you participate in AlohaCare QUEST?			**Y/N**	
Do you participate in UnitedHealthcare QUEST?			**Y/N**	
Tax ID (TIN) #				
Has your TIN recently (past 3 years) been Merged or Acquired?				
# of Providers in your TIN (provide additional details below)				

Please complete a line for each provider in your TIN & for office staff who should be included in QCIPN communication			
Name & Title	**Email Address**	**Specialty**	**NPI**

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