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, State	
Primary Practice Zip Code	
Practice Island	
Secondary Practice Location Street (if applicable)	
Secondary Practice Location City (if applicable)	
Secondary Practice Location Zip (if applicable)	
Billing Address (if different from Primary Practice)	
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).				
Are you HMSA Contracted?	**Y/N**		**HMSA Provider #**	
Do you participate in HMSA Payment Transformation for primary care providers?			**Y/N/NA**	
If yes, please attach Coreo screenshot of your PCP Performance Measure Dashboard & HMSA Panel. If not a PT Participant please attach screenshot of current Quality Measures from Primary Care First or your EMR, if available.				
If not and you are a primary care practice, are you interested in participating?			**Y/N/NA**	

Do you participate with the following programs/insurers:	**Indicate Y / N / Interested**
Primary Care First?	
AlohaCare QUEST?	
UnitedHealthcare QUEST?	
UnitedHealthcare Medicare Advantage?	
Ohana Health Plan QUEST?	
Ohana Health Plan Medicare Advantage?	
Devoted Health Medicare Advantage?	
Humana Medicare Advantage?	
Tax ID (TIN) #	
Has your TIN recently (past 3 years) been Merged or Acquired?	
# of Providers in your TIN (provide additional details on the following page)	

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Please complete a line for each provider in your TIN & for office staff who should be included in QCIPN communication (including yourself)					
Name & Title	**Email Address**	**Specialty**	**NPI**	**Gender Identity**	***CAQH #**

*CAQH ProView is a no-cost, national credentialing database available at https://proview.caqh.org

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