Independent Nurse Practitioner Enrollment Application

Please Provide your CAQH#		**NPI #**	
Date:	**Contact Person:**		
Contact Person's Email Address		**Contact Person's Phone #**	
Provider's Last Name:		**First Name:**	**Middle Initial:**
Date of Birth:	**Maiden Name if Applicable:**		**Start Date:**
Group Practice and Tax ID			
Primary Office Location:		**Suite #**	**Race/ethnicity (optional)**
City:	**State:**		**Zip Code:**
Will you be doing Telehealth services only? Y or N			
Telephone No.:		**Fax No.:**	
NYSED Certified Specialty: **Indicate how you will be practicing in the box below :**			

Mailing address if different from primary office location

Group Practice:		
Attention:		
Address:		**Suite#:**
City:	**State:**	**Zip Code:**

Email completed form to: Credentialing@IndependentHealth.com.

Please note that this document is a request for an application. It is not an application for network participation. In the event that Independent Health decides to consider this request, we will send the provider the appropriate agreements to sign. Once the signed agreements are returned and the CAQH profile is complete and updated, Independent Health will commence the credentialing process. In the event that Independent Health decides to decline to accept the request for application, the provider will be notified.

Office Use Only
I HA/NOVA Credentialing Only _____ CAQH Status _____ Date Contracts Sent: _____