Island Group Administration, Inc.

Corporate Offices
3 Toilsome Lane, East Hampton, New York 11937
Phone: (631) 324-2306 or 1-800-926-2306
Fax: (631) 324-7021 or (631) 329-0152
www.islandgroupadmin.com

- PARTICIPATING PROVIDER APPLICATION -

- ISLAND GROUP ADMINISTRATION PROVIDER NETWORK -

____ YES, I WISH TO BECOME A PARTICIPATING PROVIDER FOR ISLAND GROUP ADMINISTRATION, INC.'S SELF FUNDED PLANS. PLEASE CONSIDER THIS MY FORMAL APPLICATION. **Initials______**

NAME OF PROVIDER____

***OR PRACTICE OWNER** *LAST, FIRST, MI* *MALE/FEMALE* *DEGREE(S)*

NAME OF THE GROUP____

PROVIDERS ARE INDIVIDUALLY CREDENTIALED. PLEASE COMPLETE THE *ADD A PROVIDER TO AN EXISTING GROUP APPLICATION* FOR ADDITIONAL PROVIDERS

SPECIALTY______________________ SUB-SPECIALTIES______________________

SIGNIFICANT DISEASE(S) & ILLNESS(ES) TREATED______________________

LANGUAGES SPOKEN ______________________

MAIN OFFICE ADDRESS ______________________

____

APPOINTMENT PHONE(____)______________ FAX (____)______________

BILLING ADDRESS ______________________

____

BILLING PHONE (____)______________ FAX (____)______________

****PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL SERVICE LOCATIONS/PHONE & FAX NUMBERS****

TAX IDENTIFICATION NUMBER______________________

WEBSITE:______________________

OFFICE CONTACT/EXT:______________________

NPI #______________________ SS#______________________

UPN #______________________MEDICARE PROVIDER #______________________

LICENSURES

STATE_____ LICENSE #______________ PROFESSION___________________ EXPIRATION___/____/___

STATE_____ LICENSE #______________ PROFESSION___________________ EXPIRATION___/____/___

STATE_____ LICENSE #______________ PROFESSION___________________ EXPIRATION___/____/___

DEA REGISTRATION NUMBER_______________ EXPIRATION___/____/___

HOSPITAL AFFILIATIONS

FACILITY NAME(S)____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS

HAVE ANY DISCIPLINARY ACTIONS BEEN INITIATED OR ARE ANY PENDING AGAINST YOU BY ANY STATE LICENSURE BOARD? YES_______ NO_______

HAS YOUR LICENSE TO PRACTICE IN ANY STATE EVER BEEN LIMITED, SUSPENDED, DENIED OR REVOKED?

YES_______ NO_______

HAS YOUR DEA REGISTRATION EVER BEEN LIMITED, SUSPENDED, DENIED OR REVOKED?

YES_______ NO_______

HAVE YOU EVER LOST, OR BEEN SUSPENDED FROM, ANY HOSPITAL STAFF PRIVILAGES?

YES_______ NO_______

HAVE YOU EVER BEEN SUSPENDED, SANCTIONED, OR OTHERWISE RESTRICTED FROM PARTICIPATING IN ANY PRIVATE, FEDERAL OR STATE HEALTH INSURANCE PROGRAM?

YES_______ NO_______

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE YES_______ NO_______

SHOULD YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH THE DETAILS ON A SEPARATE SHEET

SIGNATURE____ ***DATE*** ____/____/____

DESIGNATION(S) please circle or list **MD DO DDS/DMD PHD PA NP OD CSW**_____________

ATTACHMENTS - CURRICULUM VITAE____ CURRENT LICENSES______ W-9______

DECLARATION OF MALPRACTICE INSURANCE______

CURRENT CONTROLLED SUBSTANCE REGISTRATION______

PLEASE RETURN THIS APPLICATION TO THE ADDRESS or FAX SHOWN ON THE FIRST PAGE.

THE EFFECTIVE DATE OF YOUR PARTICIPATION IS THE DATE OF THIS APPLICATION.

THE CONTRACT WILL BE SENT IN A SEPARATE PACKAGE.

SHOULD YOU HAVE ANY QUESTIONS OR TO REQUEST A FEE SCHEDULE,

PLEASE CONTACT THE PROVIDER RELATIONS DEPARTMENT AT (631)324-2306

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Credentialing a Nurse Practitioner, Physician's Assistant or Certified Nurse Midwife

Legal Group Name ______________________

Office Name or DBA ______________________

Primary Office Address ______________________

____

Phone ____________ Fax ____________

Provider :

Name ______________________

Treating Specialty ______________________

License Number ____________ Degree ____________

Start Date __________

Collaborating or Supervising Physician:

Name ______________________

Board Certification ______________________

License Number __________ Degree(s) ____________

Credentialers Name ______________________

Phone Number ______________________

4/1/16