HHC Connectx
Provider Enrollment and Referral Agreement

Provider Demographics

Last Name:	First Name:	Middle Initial:	Degree(s):	Sex:
Indicate Specialty 1: Board Certified?: ☐Yes ☐ No Certified Date:	Indicate Specialty 2: Board Certified?: ☐Yes ☐ No Certified Date:	Languages:	Email Address: Emergency phone #/pager #:	
HIV Specialist? : ☐Yes ☐ No		NY State License #:	NPI #:	
MetroPlus Health Plan Provider? : ☐Yes ☐ No Provider #: ☐ Medicaid Managed Care ☐ HIV SNP ☐ Medicare Managed Care ☐ _____				
Healthfirst Health Plan Provider?: ☐Yes ☐ No Provider #: ☐ Medicaid Managed Care ☐ Medicare Managed Care ☐ _____				

Practice Information (Please attach sheets for additional office locations.)

Practice Name:				Type of Practice: ☐ Group Practice ☐ Skilled Nursing Facility ☐ Solo Practice ☐ Nursing Home ☐ FQHC ☐ Substance Abuse Center ☐ Community Health Center ☐ Other_____			
Primary Street Address (please include Suite. No., if applicable):				City:		State:	Zip Code:
Telephone:		Fax:		Contact Person:			
Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Answering Service: ☐Yes ☐ No		Covering Provider Name & Telephone Number/Emergency (After Hours) Practice Number:					
Prefers appointment information by: ☐Mail ☐ HHCAdvantage ☐ Fax				Prefers transmission of clinical information by? ☐ Mail ☐ HHCAdvantage ☐ Fax			
Patient groups seen: ☐ Infants 0-1 ☐ Children 2-11 ☐ Adolescents 12-17		☐ Adults 18-59 ☐ Geriatrics 60+ ☐ HIV		☐ Other: _____ ☐ Other: _____ ☐ Other: _____			

Additional Practice Name:				Type of Practice: ☐ Group Practice ☐ Skilled Nursing Facility ☐ Solo Practice ☐ Nursing Home ☐ FQHC ☐ Substance Abuse Center ☐ Community Health Center ☐ Other_____			
Primary Street Address (please include Suite. No., if applicable):				City:		State:	Zip Code:
Telephone:		Fax:		Contact Person:			
Office Hours	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Answering Service: ☐Yes ☐ No		Covering Provider Name & Telephone Number/Emergency (After Hours) Practice Number:					
Prefers appointment information by: ☐Mail ☐ HHCAdvantage ☐ Fax				Prefers transmission of clinical information by: ☐ Mail ☐ HHCAdvantage ☐ Fax			
Patient groups seen: ☐ Infants 0-1 ☐ Children 2-11 ☐ Adolescents 12-17		☐ Adults 18-59 ☐ Geriatrics 60+ ☐ HIV		☐ Other: _____ ☐ Other: _____ ☐ Other: _____			

HHC Connectx

Provider Enrollment & Referral Agreement (Profile Form)

Referring Provider:

I submit this agreement as a condition of being a participating provider in the Community Provider HHC Connectx Network. I agree to use the Community Referral Office at an affiliated HHC hospital to direct my future patient referrals using the process that an HHC Connectx representative has explained to me.

As a participating provider of HHC Connectx, I understand that this process will require the exchange of clinical information (e.g., patients' medical records, medical results, consultation reports, discharge summaries) with an affiliated HHC hospital for my referred patients, all of which are highly confidential and proprietary in nature. To adhere to this process, I agree to submit the following information to the hospital's Community Referral Office either electronically (through HHCAdvantage), by fax, or by mail:

1. Statement indicating request for consultation, hospital visit, or admission.
2. The reason for the consultation, visit, or admission and/or question(s) I would like answered.
3. My thought process in deciding to request a consult, admission and/or hospital visit.
4. List of any current or past pertinent medications.
5. Any work-up/tests and results that has been done so far.
6. What I would like the treating provider at the hospital to do.

Hospital Representative:

As a representative of an HHC hospital and HHC Connectx, I agree that the hospital will adhere to the clinical information exchange process with the referring provider. This entails that the hospital will transmit back, either electronically (through HHCAdvantage), by fax, or by mail, the following:

1. A consultation report or discharge summary in response to the request for a consultation, visit, or admission.
2. What was done for the patient and results.
3. Answers to the referring provider's questions in the consult, visit or admission request and the thought process in arriving at the answers.
4. Follow-up recommendations for the referring provider and educational notes as appropriate.
5. When or under what circumstances the referring provider should consider sending the patient back to the hospital.

I agree to strictly adhere to all state and federal regulations regarding patient information. This includes, but is not limited to, final and proposed regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) and any subsequent amendments thereof.

Referring Provider:	**Hospital Representative:**
Name:	Name:
Title:	Title:
Practice Name:	Hospital Name:
Signature:	Signature:
Date:	Date: