

# *Island Group Administration, Inc.*

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

## PARTICIPATING PROVIDER NETWORK APPLICATION

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### TO BE COMPLETED BY PROVIDER

\_\_\_\_\_ YES, I WISH TO BECOME A PARTICIPATING PROVIDER FOR ISLAND GROUP  
ADMINISTRATION, INC'S SELF FUNDED PLANS  
PLEASE CONSIDER THIS AS MY LETTER OF INTENT

\_\_\_\_\_ NO, I DO NOT WISH TO BE LISTED AS A PARTICIPATING PROVIDER.

NAME (PLEASE PRINT)

NAME OF GROUP

OTHERS IN GROUP

SPECIALTY/ SUB SPECIALITY

PHONE NUMBER

FAX NUMBER

ADDRESS (BILLING)

ADDRESS (OFFICE)

(PLACE OTHER OFFICE ADDRESS / PHONES ON BACK)

OFFICE CONTACT PERSON AND TITLE

ANY PERTINENT INFORMATION REGARDING YOUR OFFICE OR PRACTICE

SIGNATURE (S)

DESIGNATION ( MD, DO, DDS, PHD, OD, etc.)

DATE

FEDERAL TAX ID (EIN #)

\*\*PLEASE ATTACH CURRENT LICENSE (S), BOARD CERTIFICATON (S),



ACCREDITATION (S), CURRICULUM VITAE AND MALPRACTICE INSURANCE.  
OTHER PLANS YOU ACCEPT (EMPIRE, VYTRA, AETNA, MDNY, etc.)

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**PLEASE NOTE: TERMINATION WILL BE BY MUTUAL AGREEMENT AND WITH A  
60 DAY NOTICE IN ORDER TO NOTIFY CLIENTS AND YOUR  
PATIENTS.**

**PLEASE MAIL TO:**

**ISLAND GROUP ADMINISTRATION, INC.  
3 TOILSOME LANE  
EAST HAMPTON, NEW YORK 11937**

**ATTENTION: LYNN R. KAPLAN**



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## **APPLICATION FOR ISLAND GROUP ADMINISTRATION, INC. PARTICIPATING PROVIDER NETWORK**

1. All information should be typed or neatly printed.
2. If more space is needed, attach additional sheets and make reference to the question to which you are replying.

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### PERSONAL IDENTIFICATION DATA

Name in full \_\_\_\_\_

Date of application \_\_\_\_\_

Office address (List additional locations on back) \_\_\_\_\_

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)

Billing address (If different) \_\_\_\_\_

Appointment Phone ( ) \_\_\_\_\_ Billing Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ UPIN # \_\_\_\_\_

Federal ID # \_\_\_\_\_ Medicare Prov # \_\_\_\_\_

### PROFESSIONAL DATA

A. SPECIALTY \_\_\_\_\_ SUB SPECIALTY \_\_\_\_\_

Group Name \_\_\_\_\_

B. LICENSURES (Specify Profession) \_\_\_\_\_

Attach Copies:

State \_\_\_\_\_ License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

State \_\_\_\_\_ License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

State \_\_\_\_\_ License # \_\_\_\_\_ Expiration Date \_\_\_\_\_

DEA Reg # \_\_\_\_\_ Expiration Date \_\_\_\_\_



C. Please answer each of the following questions completely. If the answer to them is yes, please provide a full explanation of the details on a separate sheet.

1. Have any disciplinary action been initiated or are any pending against you by the state licensure board?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Has your license to practice in any state ever been limited, suspended, denied or revoked?

Yes \_\_\_\_\_ No \_\_\_\_\_

3. Has your DEA registration ever been limited, suspended, denied or revoked?

Yes \_\_\_\_\_ No \_\_\_\_\_

4. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (for example, Medicare or Medicaid)?

Yes \_\_\_\_\_ No \_\_\_\_\_

5. Have you ever been convicted of a criminal offense?

Yes \_\_\_\_\_ No \_\_\_\_\_

6. Have you ever lost or been suspended from hospital staff privileges?

Yes \_\_\_\_\_ No \_\_\_\_\_

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SIGNATURE

DATE

**PLEASE ATTACH A COPY OF YOUR:**

**CURRICULUM VITAE  
INSTITUTIONAL AFFILIATIONS  
LICENSES  
MALPRACTICE INSURANCE INFO**

