



Hospital-Based Practitioners

INSTRUCTIONS

This form should be completed by physicians or other healthcare professionals who are ONLY affiliated with a hospital-based practice that are seeking to join the Horizon Managed Care Network and Horizon PPO Network or the Horizon NJ Health Networks.

Practitioners who are affiliated with an office-based practice must complete and provide the information outlined in our [Physician Application Checklist](#) or our [Other Healthcare Professional Application Checklist](#), as appropriate, to be considered for participation in our network(s).

Pathologists affiliated with an office-based practice are not eligible to participate in our Horizon Managed Care Network.

Completed and signed forms may be mailed to:
Horizon BCBSNJ Credentialing & Recredentialing Department
Three Penn Plaza East, PP-14C
Newark NJ 07105-2200

You may also email information to EnterprisePDM@HorizonBlue.com
(email submission accepted only for the duration of the COVID-19 public health emergency)

PRACTITIONER INFORMATION

Practitioner Name _____

Practitioner Degree _____

Practitioner Specialty _____

Practitioner Date of Birth _____

Practitioner National Provider Identifier (NPI) _____

Social Security Number _____

Gender

Female

Male

(Continues)

32255 (0821)

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Practitioner Race and Ethnicity

Although not required, we encourage you to provide information about your race/ethnicity to help us address racial and ethnic health disparities in the communities we serve.

Choosing *not* to disclose this information will have no impact on your credentialing or your participation in our network(s).

Practitioner Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race
- Unknown
- I prefer not to respond

Practitioner Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- I prefer not to respond

Network Participation

I am seeking to be credentialed to join the:

- Horizon PPO Network
- Horizon Managed Care Network
- Horizon NJ Health Networks

Disclosure Statement *(for Horizon NJ Health Only)*

- Federal and state regulations require that providers seeking to participate in our Horizon NJ Health network provide a completed copy of our [Disclosure Statement: Individual Practitioners and Groups of Practitioners](#). Consult your legal counsel if you have questions regarding this form.

21st Century Cures Act *(for Horizon NJ Health Only)*

- If you've not already done so, practitioners seeking to participate with our Horizon NJ Health networks must register with the State of New Jersey under the 21st Century Cures Act. Visit our [21st Century Cures Act](#) webpage for information about this requirement as well as details about how to register with the State of New Jersey.

PRACTITIONER INFORMATION

Group Practice Name _____

Group Tax Identification Number (TIN) _____

County _____

PRIMARY LOCATION

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

(Continues)

OTHER LOCATIONS

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

Network Hospital Name _____

Network Hospital Address _____

Telephone Number _____

BILLING ADDRESS

Billing Address _____