For internal use only

☐ CA1 | ☐ B | ☐ 1
☐ 2
☐ CA2 | ☐ O | ☐ 3
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☐ G | ☐ 5
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☐ 9

Letter of Interest Questionnaire

This form may supplement, or replace, a letter of interest for our provider network. Please answer the following questions. This information will help us in assessing your qualifications with the service needs of our network. Once completed, please fax to 832-825-8750, Attn: LOI Committee. For questions, call 832-828-1008.

Demographic Information

Name: ____

Is this a group practice? _______ Group name: ______________________________________

Service address: ______________________________________ Zip code__________

Billing address: ______________________________________ Zip code__________

Phone: ____________________ Fax: ____________________ Tax ID number: ____________________

NPI number: ________________ (required) TPI number: ________________ (required)

Specialty: ____

Provider Service Information

1) What services do you provide?

____

____

____

2) What is unique about the services you provide?

____

____

____

3) Will you accept both STAR and CHIP members/patients? ☐ Yes ☐ No

4) What are your hours of operation? ______________________________________

5) If you are a behavioral health provider do you provide home visits? ☐ Yes ☐ No

6) If you are a PCP do you provide EPSDT services? ☐ Yes ☐ No

7) Do you participate in the VFC program? ☐ Yes ☐ No

8) What other Medicaid and CHIP plans are you enrolled?

____

____

9) Which hospitals do you have admitting privileges?

____

____

Important: Please include your W-9 form with this questionnaire.