Network Participation Form

Texas Children's Health Plan®

Please complete the questionnaire in its entirety and return with a **copy of W-9 (required)** by fax: 832-825-9360 or email TCHP CA Contact Admin: jointchp@texaschildrens.org. Incomplete forms will not be considered.

Today's Date:	Programs of Interest: ☐ STAR ☐ CHIP ☐ CHIP Perinate ☐ STAR Kids

☐ Provider already in-network – Adding new product: ☐ STAR ☐ CHIP ☐ CHIP Perinate ☐ STAR Kids

PROVIDER TYPE (please check appropriate box)

☐ PCP ☐ Specialist ☐ Hospital ☐ Facility ☐ Ancillary (specify:_____) ☐ Behavioral Health (specify:_____)
☐ LTSS (specify:_____) ☐ Other (specify:_____) ☐ Hospital-Based

PROVIDER DEMOGRAPHICS

First MI Last Healthcare Credentials (MD, DO, LPC, NP, APN, PA etc.)

Name:

License #:	License Type:
Primary Specialty:	Secondary Specialty:
Individual NPI:	Tax ID:
Supervising Physician (if applicable):	Supervising Physician NPI:

Is this a group practice? ☐ Yes ☐ No	Group Name:	
	Group NPI:	Group Tax ID:

- **Supervising Physician** is needed for all Physician Extenders.
- **Medical Director** is needed for: Behavioral Health entities.
- **Hospital Admitting Privileges:** PCPs and Specialists must include full name of hospitals.
- Each address (primary/alternate) must be enrolled through TMHP.
- **Secretary of State Website/Texas Comptroller of Public Accounts:** Must have the right to transact business in the state of Texas.

HOSPITAL PRIVILEGES

Do you have hospital admitting privileges? ☐ Yes ☐ No If yes, please list hospital(s)_____

_____

If no, please explain how hospital admittance is handled? _____

_____

PROVIDER CONTACT INFORMATION

Name and Title:		
Phone:	Fax:	Email Address:
Signing Authority Name:	Phone:	Email:

DEMOGRAPHIC/BILLING INFORMATION

Physical Address:	Billing Address:
Phone:	Phone:
Fax:	Fax:
Days/Hours of Operation:	

PROVIDER SERVICE INFORMATION (check all that apply. If other, please list.)

What services are provided? (Check all that apply. If other, please list.) ☐ Children ☐ Adults ☐ Pregnant Women ☐ Other _____

What languages are spoken? (Check all that apply. If other, please list.) ☐ English ☐ Spanish ☐ Other _____

What type of patients are currently being seen in your office? ☐ VFC ☐ EPSDT ☐ Other _____

Counties served:

I am a Physician Extender and I qualify for the Drug Addiction Treatment Act (DATA) waiver. ☐ Yes ☐ No

Are home visits provided? ☐ Yes ☐ No

FOR BEHAVIORAL HEALTH PROVIDERS ONLY

Are you able to schedule a patient/member within 7 days of discharge from an inpatient facility? ☐ Yes ☐ No

For providers who offer the below services to Medicaid and CHIP members, please refer to the following links/phone numbers to contract:
Pharmacy: www.navitus.com; Vision Services: Envolve 1-800-879-6901; Dental Services: Denta Quest 1-877-493-6282/MCNA Dental 1-800-494-6262