Letter of Interest Questionnaire

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: tchpnetworkmanagement@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

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

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

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

- **Supervising Physician** is needed for all Physician Extenders
- **Medical Director** is needed for: Facilities, Urgent Care Centers, Targeted/Case Management, RHC, FQHC, Physician Extenders, and Behavioral Health Facilities
- **Hospital Admitting Privileges:** PCPs and Specialists must include full name of hospitals
- Physical address must be attested through TMHP to individual NPI and group NPI (if applicable)
- **Secretary of State Website/Texas Comptroller of Public Accounts:** Name and address (must reflect physical address on LOI) and 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