Texas Children's Health Plan

Provider Information Form

Please submit completed form **copy of W-9 (required)** by fax: 832-825-9360 or email TCHP CA Contact Admin: tchpnetworkmanagement@texaschildrens.org. For a group practice, complete a Provider Information Form (PIF) for each provider.

Today's Date:

TYPE OF REQUEST

- ☐ New provider
- ☐ New provider to a participating group
- ☐ Participating group adding a new location
- ☐ Termination (Please attach written termination notice as specified in the Services Agreement)
- I am a Physician Extender and I qualify for the Drug Addiction Treatment Act (DATA) waiver. ☐ Yes ☐ No

PROVIDER TYPE

☐ Ancillary	☐ Behavioral Health	☐ FQHC/RHC
☐ Hospital Based	☐ Physician Extender	☐ Primary Care
☐ Specialist	☐ Urgent Care Clinic	☐ Other (specify: _____)

PROVIDER INFORMATION

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

Provider SSN: Provider DOB:	Gender: ☐ M ☐ F
Provider NPI:	Is NPI attested: ☐ Yes ☐ No
Provider TPI:	Provider TIN:
Primary Specialty:	Provider License Number:
Secondary Specialty:	CAQH:
Group Name (if applicable):	
Group NPI:	Is group NPI attested: ☐ Yes ☐ No
Group TIN:	Group TPI:

PHYSICIAN EXTENDER

Is the Physician Extender acting as PCP? ☐ Yes ☐ No If acting as a PCP, complete "Request to Serve as PCP" form.

Please complete the following information as it is listed with TMHP.

NOTE: Individual NPI must be attested to all the addresses listed. NPI must be attested to the address on TMHP.

PRIMARY ADDRESS

NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:

ALTERNATE ADDRESS

NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:
NPI:	Phone:	Fax:	
Street Address:	City:	State:	Zip:

CREDENTIALING CONTACT

Contact Person:	Phone:
Email:	

Thank you for your interest in joining Texas Children's Health Plan, Inc. If Texas Children's Health Plan determines there is a network need, we will initiate the credentialing process. Please be advised of the following practitioner rights under NCQA for practitioners who are undergoing the credentialing process:

1. Practitioners have the right to review information submitted by outside sources (malpractice insurance carriers, state licensing boards, etc.) to support their credentialing application. Texas Children's Health Plan is not required to make available references, recommendations or peer review protected information.
2. Practitioners have the right to correct erroneous information identified in their credentialing application. Corrections must be submitted in writing to the Texas Children's Health Plan Credentialing Department at Credentialingresponse@texaschildrens.org within (10) days.
3. Practitioners have the right to receive the status of their credentialing or re-credentialing application, upon request, by emailing the Credentialing Department at Credentialingresponse@texaschildrens.org.

REQUEST TO SERVE AS A PRIMARY CARE PRACTITIONER	
Applicant name:	Date:
Supervising Physician:	Supervising Physician NPI:
Office Address:	
Office Phone Number:	

Please provide the following information:

1. Do you have delegated prescribing authority? ☐Yes ☐No
2. What is the name of your supervising physician as registered with the Texas State Board of Medical Examiners?
   Name of supervising physician: _____
3. Is your supervising physician credentialed to serve as a PCP for the Texas Children's Health Plan network? ☐Yes ☐No
   If yes, what lines of business is your supervising physician contracted for as a PCP? ☐CHIP ☐STAR ☐STAR Kids
4. How many years have you practiced as an Advanced Practice Nurse in the field of pediatrics or Family Practice? _____ years

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If accepted as a Texas Children's Health Plan, Inc. PCP, my supervising physician and I agree to the following:

- Supervising physician and I agree to give a 90-day written notice to Texas Children's Health plan prior to my leaving the Texas Children's Health Plan network.
- My supervising physician and I agree to give immediate written notice to Texas Children's Health Plan of any change in status which makes the supervising physician unable to carry out his/her duties as defined by Texas State Board of Medical Examiners or Texas Board of Nurse Examiners.
- My supervising physician and I agree to notify Texas Children's Health Plan of any intentions to change the supervising physician listed with TSBME and/or TSBNE prior to any change. I understand and agree that for any product in which I serve as a PCP, the new supervising physician must be a participating PCP in the Texas Children's Health Plan network in order for me to continue to serve as a PCP.
- I agree to immediately forward copies of communications from TSBME and TSBNE communicating that a change in supervising physician has occurred.
- My supervising physician and I agree that there will be no periods of time in which I am without a supervising physician who is a participating PCP in the Texas Children's Health Plan provider network and/or lines of busin ess.
- Except for emergent situations, the supervising physician agrees to evaluate any Texas Children's Health Plan member seen by the APN or PA prior to referring to a specialist.
- The supervising physician agrees to provide appropriate PCP services that cannot be provided by the APN or PA such as prescribing of controlled substances or inpatient attending services. Another in-network physician may provide in-patient attending services when the supervising physician has made the arrangements.
- The APN or PA agrees to be held accountable for all policies and procedures addressed in the Texas Children's Health Plan Provider Handbook that are required of PCPs.
- In order to serve as a participant in the Texas Children's Health Plan network it is understood by all parties that both the supervising physician and APN or PA are agreeing to practice within the scope allowed by the TSBME and/or TSBNE regulations.
- A copy of the policies or protocols developed, implemented and reviewed annually by the PCP and APN or PA are attached.

I understand that I am automatically terminated from Texas Children's Health Plan network when my supervising physician is terminated.

Signature of Applicant Date

Signature of Supervising Physician Date

Attach a written recommendation from the supervising physician recommending the APN or PA to service as a PCP and attesting in writing to the APN or PA's competency to serve in this capacity.