Texas Children's Health Plan
The best decision a family can make.

Internal Use Only	
☐ B	☐ 2
☐ O	☐ 4
☐ G	☐ 7
Received Date	_____
Received by	_____

Provider Information Form

Please submit completed form with a current W-9 to tchpnetworkmanagement@texaschildrens.org.
For a group practice, please complete a Provider Information Form (PIF) for each provider.

Date: _____

Type of Request

☐ New Provider	☐ Termination (Please attach written termination notice as specified in the Services Agreement)

Provider Information

Provider Name			
Provider DOB		Gender	☐ M ☐ F
Provider NPI		Is NPI attested?	☐ Y ☐ N
Provider TPI		Provider TIN	
Primary Specialty		Secondary Specialty	
Provider License Number		CAQH#	
Group Name (if applicable)			
Group NPI		Is group NPI attested?	☐ Y ☐ N
Group TIN		Group TPI	

Provider Type

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

Physician Extender

Is the physician extender, acting as PCP?	☐ Yes If acting as a PCP, complete "Request to Serve as PCP" form	☐ No

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

Primary Address

Street Address	City	State	Zip
Phone	Fax		

Alternate Address

Street Address	City	State	Zip
Phone	Fax		

Billing Address

Street Address	City	State	Zip
Phone	Fax		

Credentialing Contact

Contact Person	
Email	
Phone	

Thank you for your interest in joining Texas Children's Health Plan, Inc. If TCHP 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. TCHP 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 TCHP 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.

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REQUEST TO SERVE AS A PRIMARY CARE PRACTITIONER

DATE	
APPLICANT NAME	
SUPERVISING PHYSICIAN	
OFFICE ADDRESS	
OFFICE TELEPHONE 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?

   _____

3. Is your supervising physician credentialed to serve as a PCP for the Texas Children's Health Plan Network?

   ☐ Yes ☐ No

   If yes, what TCHP lines of business is your supervising physician contracted for as a PCP?

   ☐ CHIP
   ☐ Medicaid

4. How many years have you practiced as an Advanced Practice Nurse in the field of pediatrics or Family Practice?

   _____

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 TCHP network.
- My supervising physician and I agree to give immediate written notice to TCHP 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 TCHP 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 TCHP 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.

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- 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 TCHP provider network and/or lines of business.
- Except for emergent situations, the supervising physician agrees to evaluate any TCHP 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 TCHP Provider Handbook that are required of PCPs.

- In order to serve as a participant in the TCHP 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 TCHP 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.