Texas Children's Health Plan

Please print clearly or type all of the information on this form.
Email or fax the completed form and any additional documentation to the email address and/or fax number listed at the bottom of the form.

Provider Name _____

DOB _____/_____/_____ Gender _____ Social Security # _____

Individual NPI _____ Licensure Number _____

Languages Spoken _____

Specialty: _____ Primary _____ Secondary _____

Group name (if applicable) _____

Group NPI _____ Group TIN _____ THSteps TPI number _____

Service address _____

City _____ State _____ Zip_____

Phone _____ Fax _____

Secondary Service address _____

City _____ State _____ Zip_____

Phone _____ Fax _____

Billing address _____ PO Box _____

City _____ State _____ Zip_____

Phone _____ Fax _____

Provider Type: ❍ Primary Care ❍ Specialist ❍ Behavioral Health ❍ Ancillary ❍ Urgent Care Clinic
❍ Hospital Based ❍ LMFT ❍ MHMR ❍ FQHC

Credentialing Contact Name _____

Email _____ Phone _____

- Important -
Please include a copy of the current W-9 when submitting this form.

Submit completed form via email to:
tchpnetworkmanagemen@tchp.us
or fax to 832-825-9360 attention Contracts Administration.
If any questions, please call 832-828-1063.