



Letter of Interest Questionnaire

Complete the form in its entirety and return with a **copy of W-9 (required)** by fax 832-825-9360 or email TCHPNetworkManagement@texaschildrens.org. Incomplete Forms will not be considered.

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

Provider Type (Please check appropriate box)

<input type="checkbox"/> PCP	<input type="checkbox"/> Specialist	<input type="checkbox"/> Hospital	<input type="checkbox"/> Ancillary (_____)	<input type="checkbox"/> Behavioral Health (Specify _____)
<input type="checkbox"/> LTSS (Specify _____)			<input type="checkbox"/> Other (_____)	<input type="checkbox"/> Please check if you are a hospital-based provider

Provider Demographics

Name:		License #:	License Type:
Primary Specialty:		Secondary Specialty:	
Individual NPI:		Individual TPI:	Tax ID:
Supervising Physician (if applicable):		Supervising Physician NPI:	
Is this a group practice? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group Name:	Group TPI:	
	Group NPI:	Group Tax ID:	

Hospital Privileges

Do you have hospital admitting privileges?	<input type="checkbox"/> Yes	Please list:
If <i>no</i> , please explain how hospital admittance is handled?		

Provider Contact Information

Name and Title:			
Phone:	Fax:	Email:	

Demographic/Billing Information

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

Provider Service Information

What services are provided? (Check all that apply. If <i>other</i> , please list.) <input type="checkbox"/> Children <input type="checkbox"/> Adults <input type="checkbox"/> Pregnant Women <input type="checkbox"/> Other
What languages are spoken? (Check all that apply. If <i>other</i> , please list.) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
What type of patients are currently being seen in your office? <input type="checkbox"/> VFC <input type="checkbox"/> EPSDT <input type="checkbox"/> Other
Counties served:

For Behavioral Health Providers Only

Are home visits provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you able to schedule a patient/member within 7 days of discharge from an inpatient facility? <input type="checkbox"/> Yes <input type="checkbox"/> No
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For Internal Use Only

Received By:	Received Date:
Verified NPI Attestation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Verified TMB/OIG: <input type="checkbox"/> Yes <input type="checkbox"/> No
Completed By:	Completed Date:

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 - Superior Vision 1-800-879-6901
 Dental Services - FCL Dental 1-877-493-6282/MCNA Dental 1-800-494-6262