Participation Criteria Attestation

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Thank you for your interest in becoming a Participating Provider with the Community Health Choice Provider Network. Community is focused on continuous monitoring of provider network adequacy, full transparency in provider communication, a staunch commitment to quality, and elimination of administrative burdens, amongst other items.

For each physician or healthcare professional participating in your practice, please review the Physician Participation Criteria below and check each element with which your practice complies.

Criteria Type	Criteria	Medicaid	CHIP	Health Insurance Marketplace	Notes	Indicate Criteria Met	Comments
Regulatory	Participation in THSteps	Yes	N/A	N/A	Applies to PCP Providers only	☐	
	Participation in Wellness	N/A	Yes	Yes	Applies to PCP Providers only	☐	
	Attested NPI Number	Yes	Yes	N/A		☐	
	Medicare Number (preferred)	Yes	Yes	Yes	Does not apply to pediatric or OB/GYN Providers	☐	
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes		☐	
	Not currently on Govt. Exclusion List	Yes	Yes	Yes		☐	
Administrative	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes		☐	
	Facsimile	Yes	Yes	Yes		☐	
	Hospital Privileges at Participating Hospital or Surgery Center	Yes	Yes	Yes	Or advanced approval of acceptable coverage (e.g., hospitalist or designation)	☐	
	Submission of authorization requests via Provider Portal	Yes	Yes	Yes		☐	
	EDI - Electronic Claims Submission	Yes	Yes	Yes	Through existing clearinghouse partnerships	☐	☐ Availity ☐ Change Healthcare ☐ Relay Health ☐ Trizetto
	EDI - Electronic Funds Transfer	Yes	Yes	Yes		☐	
	EDI - Electronic Remittance Advice	Yes	Yes	Yes		☐	
	Adherence to HIPAA Standard Transactions	Yes	Yes	Yes		☐	
	Participation in CAQH program	Yes	Yes	Yes		☐	
Quality	Mandatory Signature on Community's Commitment to Quality	Yes	Yes	Yes	Applies to PCPs and OB/GYNs only	☐	

If you are part of a group, <u>each</u> physician within the practice must complete a separate Participation Criteria Attestation.

Print Physician Name **Signature** **Date**

Community will acknowledge receipt of request within 10 business days. Community's <u>Provider Review Committee</u> will consider your request and notify you once the committee renders a decision. Determinations based on network need and current availability of services. All providers are subject to Community's Credentialing requirements and applicable state and federal guidelines as set forth in the Community participating provider agreement. Requesting, obtaining, or submitting this form does <u>not</u> guarantee or imply that Community will accept your participation in the Community network, nor does it entitle you to payment of any services rendered to a Community Member prior to your receiving written confirmation of an effective date and meeting any and all applicable authorization requirements.

PHYSICIAN OR HEALTHCARE PROFESSIONAL NETWORK INTEREST PROFILE FORM

COMMUNITY HEALTH CHOICE

Please complete this form in its entirety and return with a copy of **W-9** by
fax 713-295-7058 or email CHC.Contracting@communityhealthchoice.org.
Incomplete forms *not* considered.

Today's Date	☐ **Participating Provider already in the network, but would like to participate in additional program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **CHIP Perinatal** ☐ **Marketplace**
	☐ **Provider NOT in the network, but would like to participate in the following program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **CHIP Perinatal** ☐ **Marketplace**

Physician or Healthcare Professional Information

Desired role: ☐ **PCP** ☐ **Specialist** ☐ **Hospital-based Provider**

Provider Name:

Primary Specialty: **Board Certified:** ☐ **Yes** ☐ **No**

Secondary Specialty: **Board Certified:** ☐ **Yes** ☐ **No**

CAQH Number:
(please use this time to re-attest and update your credentialing documents)

Individual NPI: **Individual THSteps #:** **Medicare #:** **Medicaid #:**

If Group and includes other Providers, please complete Page 2.

Hospital privileges? ☐ **Yes** **Please provide Hospital Name(s):**

If No, please explain how hospital admittance is handled?

If you render services at a Surgery Center, please list:

If NP or PA, name of supervising physician: **Supervising physician's NPI:**

Provider Contact Person: **Contact Phone:**

Contact Email: **Contact Fax:**

Contact Mailing Address:

City, State, Zip:

Billing Information

Provider Group / Billing Name:

Tax ID: **Group NPI:**

Is provider joining an existing group of providers who is currently participating with Community? ☐ **Yes** ☐ **No**

Clearinghouse: **Medicaid/CHIP:** ☐ **Availity** ☐ **Change Healthcare** ☐ **Relay Health** ☐ **Trizetto**

Marketplace: ☐ **Change Healthcare** ☐ **Relay Health**

Payment Method: ☐ **Direct Deposit (EFT)** ☐ **ERA**

Payment Method: ☐ **Direct Deposit (EFT)** ☐ **ERA**

Service Location Information

Provider's Practice Address:

Primary Contact: **Phone Number:** **Fax Number:**

Bus Route: ☐ **Yes** ☐ **No** **Walk-ins Accepted:** ☐ **Yes** ☐ **No** **Electronic Medical Records:** ☐ **Yes** ☐ **No**

Days and Hours of Operation: (e.g., Mon. 7 a.m. – 7 p.m.) **Sun:** _____ **Mon:** _____ **Tue:** _____ **Wed:** _____

Thu: _____ **Fri:** _____ **Sat:** _____ **Holidays:** _____

Languages spoken: ☐ **Arabic** ☐ **Chinese-Cantonese** ☐ **Chinese-Mandarin** ☐ **Hindi**

☐ **Sign Language** ☐ **Spanish** ☐ **Vietnamese** ☐ **Other:** _____

Additional practice locations? ☐ **Yes** ☐ **No** **If yes, include a separate sheet with additional information.**

COMMUNITY HEALTH CHOICE

PHYSICIAN AND HEALTHCARE PROFESSIONAL INFORMATION

List all Physician, Nurse Practitioners, and Physician Assistants at the location to be listed in the Provider Directory.
Upon credentialing verification, the provider specialty indicated will also be listed in the directory.
Use a separate sheet for additional spaces.

Program Participation Interest	Name and CAQH #	Provider Type/ Specialty or Status	Membership assignment if PCP designation	Individual NPI	Federal Tax ID	Medicare #	Patient Type Accepted	Patient Age Range	Hospital or Surgery Center Privileges	Language(s) Spoken
☐ CHIP ☐ CHIP Perinatal (OBs only) ☐ Medicaid/STAR ☐ Marketplace	*Name:* *CAQH#:*_____	☐ PCP ☐ Specialist ☐ Other: _____ _____ _____	☐ Individual ☐ Group ☐ Location				☐ Children ☐ Adults ☐ Pregnant Women	☐ 0-18 ☐ 6-18 ☐ 18-99 ☐ Other: _____		
☐ CHIP ☐ CHIP Perinatal (OBs only) ☐ Medicaid/STAR ☐ Marketplace	*Name:* *CAQH#:* _____	☐ PCP ☐ Specialist ☐ Other: _____ _____ _____	☐ Individual ☐ Group ☐ Location				☐ Children ☐ Adults ☐ Pregnant Women	☐ 0-18 ☐ 6-18 ☐ 18-99 ☐ Other: _____		
☐ CHIP ☐ CHIP Perinatal (OBs only) ☐ Medicaid/STAR ☐ Marketplace	*Name:* *CAQH#:*_____	☐ PCP ☐ Specialist ☐ Other: _____ _____ _____	☐ Individual ☐ Group ☐ Location				☐ Children ☐ Adults ☐ Pregnant Women	☐ 0-18 ☐ 6-18 ☐ 18-99 ☐ Other: _____		
☐ CHIP ☐ CHIP Perinatal (OBs only) ☐ Medicaid/STAR ☐ Marketplace	*Name:* *CAQH#:*_____	☐ PCP ☐ Specialist ☐ Other: _____ _____ _____	☐ Individual ☐ Group ☐ Location				☐ Children ☐ Adults ☐ Pregnant Women	☐ 0-18 ☐ 6-18 ☐ 18-99 ☐ Other: _____		

INTERNAL USE ONLY	
Received by:	**Received date:**