COMMUNITY HEALTH CHOICE

LTSS Ancillary Provider Participation Criteria

Thank you for your interest in becoming a Participating Provider with the Community Health Choice Network. Please take a moment to review the Ancillary Participation Criteria below and check each element with which your business complies.

Criteria Type	Criteria	Medicaid	CHIP	Health Insurance Marketplace	Notes	Indicate Criteria Met	Comments
Regulatori	Valid Texas Medicaid Number	Yes	Yes	N/A		☐	
	Attested NPI Number	Yes	Yes	N/A		☐	
	Medicare Number (*required*)	Yes	Yes	Yes		☐	
	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		☐	
	If Hospital has 50 beds or more: (i) has a quality assessment and performance improvement program as specified in 42 CFR 482.21; and (ii) has discharge planning as specified in 42 CFR 482.43.	N/A	N/A	Yes		☐	
Administrati	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		☐	

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

Community's Network Access Committee 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 participating provider agreement. Requesting, obtaining, or submitting this form does not guarantee or imply acceptance of participation in the Community network, nor does it entitle you to payment of any services rendered.

LTSS ANCILLARY NETWORK INTEREST PROFILE FORM

Please complete this form in its entirety and return with a copy of **W-9 to** STARPLUSPROVIDERINQUIRY@Communityhealthchoice.org .

Incomplete forms not considered.

Today's Date	☐ Provider would like to participate in the following program(s):	☐STAR ☐ STAR+PLUS ☐CHIP ☐ CHIP Perinatal ☐ Marketplace ☐ D-SNP

Legal Name: _____ **Operating / DBA Name** _____

NPI: **TIN:** **Medicare #:** **Medicaid #:**

Contact Person: **Title:**

Email: **Phone:** **Fax:**

Mailing Address: **City:** **ST:** **Zip Code:**

1. **Area of Coverage** ***(check all counties served):***

☐Austin	☐Matagorda
☐Brazoria	☐Montgomery
☐Chambers	☐Newton
☐Fort Bend	☐Orange
☐Galveston	☐Polk
☐Hardin	☐San Jacinto
☐Harris	☐Tyler
☐Jasper	☐Walker
☐Jefferson	☐Waller
☐Liberty	☐Wharton

2. **Services provided:** ***(Must be licensed to provide services. Check all that apply as licensed.)***

☐ Adaptive Aids/Medical Supplies/Durable Medical Equipment Supplies (DME)	☐Personal Attendant Services (PAS)
☐ Adult Foster Care	☐Personal Care Assistant
☐ Assisted Living & Residential Care Services	☐Private Duty Nursing (PDN)
☐ Consumer Directed Services (CDS) Agency	☐Respite Care (facility based)
☐ Day Activity and Health Services (DAHS)	☐Respite Care (in-home)
☐ Emergency Response Services (ERS)	☐Support Management
☐ Adult Foster Care	☐Supported Employment
☐ Consumer Directed Services (CDS) Agency	☐Therapy - Occupational
☐ Day Activity and Health Services (DAHS)	☐Therapy - Physical
☐Financial Management Services (FMS) (CDS only)	☐Therapy - Speech
☐ Habilitation Services	☐ Home Delivered Meals
☐Flexible Family Supports	☐Therapy (In-Home) - Occupational

Primary Address

Address Location Name: **Phone:** **Fax:**

City: **State:** **Zip:**

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

Operating Hours (Ex: Mon-Fri 8am-5pm)

MON Hours	TUE Hours	WED Hours	THU Hours	FRI Hours	SAT Hours	SUN Hours	HOLIDAYS Yes ☐ No ☐

Languages spoken: ☐Arabic ☐ Chinese-Cantonese ☐ Chinese-Mandarin ☐ Hindi ☐ American Sign Language ☐ Spanish ☐ Vietnamese

Clearinghouse:

Medicaid/CHIP: ☐Availity ☐ Change Healthcare ☐ Relay Health ☐ Trizetto **Payment Method:** ☐Direct Deposit (EFT) ☐ERA

Marketplace: ☐Change Healthcare ☐ Relay Health **Payment Method:** ☐ Direct Deposit (EFT) ☐ERA

Alternate Address

Address Location Name: **Phone:** **Fax:**

City: **State:** **Zip:**

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

Operating Hours (Ex: Mon-Fri 8am-5pm)

MON Hours	TUE Hours	WED Hours	THU Hours	FRI Hours	SAT Hours	SUN Hours	HOLIDAYS Yes ☐ No ☐

Languages spoken: ☐Arabic ☐ Chinese-Cantonese ☐ Chinese-Mandarin ☐ Hindi ☐ American Sign Language ☐ Spanish ☐ Vietnamese

Clearinghouse:

Medicaid/CHIP: ☐Availity ☐ Change Healthcare ☐ Relay Health ☐ Trizetto **Payment Method:** ☐Direct Deposit (EFT) ☐ERA

Marketplace: ☐Change Healthcare ☐ Relay Health **Payment Method:** ☐ Direct Deposit (EFT) ☐ERA

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