COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Participation Criteria Attestation

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 to provide services needed to our members. For each physician or practitioner participating in your practice, please review the Physician Participation Criteria below and check each element with which your practice complies.

Requirements	Medicaid	CHIP	Health Insurance Marketplace	D-SNP	Indicate Criteria Met
Participation in THSteps **(PCPs only)**	Yes	Yes	N/A	N/A	☐
Valid NPI Number **(Must be attested for participation in Medicaid programs)**	Yes	Yes	N/A	Yes	☐
Medicare Number **(Does not apply to pediatric or OB/GYN providers only participating in Medicaid programs)*****Effective March 1, 2024, LPC and LFMT providers must be enrolled in Medicare.*****	Yes	Yes	Yes	Yes	☐
Answering Service - Access to Live Person or callback from live person within 30 minutes of call	Yes	Yes	Yes	Yes	☐
Not currently on Govt. Exclusion/Preclusion List	Yes	Yes	Yes	Yes	☐
Hospital Privileges at Participating Hospital or Surgery Center **(Or advanced approval of acceptable coverage (e.g., hospitalist)**	Yes	Yes	Yes	Yes	☐
EDI - Electronic Claims Submission through existing clearinghouse partnerships. Availity Change Healthcare Relay Health Trizetto	Yes	Yes	Yes	Yes	☐
EDI - Electronic Funds Transfer	Yes	Yes	Yes	Yes	☐
EDI - Electronic Remittance Advice	Yes	Yes	Yes	Yes	☐
Participation in CAQH program	Yes	Yes	Yes	Yes	☐

Each practitioner within a group practice must complete a separate Participation Criteria Attestation and Network Interest Profile Form.

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

Community will acknowledge receipt of request within ten business days. Community's Network Access Committee will consider your request within 30 days and notify you when the committee renders a decision. Determinations are 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 not 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 all applicable authorization requirements.

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Physician/Practitioner Network Interest Profile

Please complete this form in its entirety and return to
CHC.Contracting@CommunityHealthChoice.org .

Participating provider adding programs? ☐	STAR ☐	CHIP ☐	CHIP-Perinatal ☐	D-SNP ☐	Marketplace ☐	STAR+PLUS ☐
New provider requesting to join network? ☐	STAR☐	CHIP☐	CHIP-Perinatal ☐	D-SNP ☐	Marketplace☐	STAR+PLUS ☐

Physician/Practitioner Information

Desired Role:	PCP ☐	Specialist ☐	Behavioral Health ☐	Hospital-Based Provider ☐	Telehealth Only ☐

Provider Name:		Provider Degree: (MD, NP etc.)	NPI:

Primary Specialty:		Board Certified?☐	Secondary Specialty:		Board Certified? ☐

CAQH #:	Medicare #:	Medicaid#:	Individual THSteps #:
Hospital privileges? Yes ☐	Please provide Hospital Name(s):	If No, please explain how hospital admittance is handled?	

Electronic submission of prescriptions (e-Prescribe)☐	
Name of Surgery Center, where services are provided (if applicable):	Unique services provided:

Supervising Physician Name:		Supervising Physician NPI:

Provider Contact Name:		Contact Phone:	
Contact Email:		Contact Fax:	

Provider Website:
Provider Email Address:

Service Location Information (Include a separate list of additional locations as needed)

Provider's Primary Practice Address		List in Directory? ☐	Accepting New Patients? ☐

Primary Contact Name:	Phone #:	Fax #:

Office Hours:	Sun:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:

Handicap Accessible: Building ☐ Restrooms ☐ Parking ☐		On Bus Route? ☐	
Age Limits:	Gender Restrictions:	Same Day Walk-Ins? ☐	Electronic Medical Records☐
Vaccines for Children Provider? ☐	Maternal Mental Health Provider? ☐	Texas Healthy Women Provider? ☐	Telehealth Services? ☐

SPECIAL/UNIQUE SERVICES PROVIDED:

Expertise in treating patients with Opioid Use Disorder:

□OUD - Addiction Specialist
□OUD - Opioid Treatment Program (OTP) □OUD – SBIRT
□OUD - Prescriber of Medications
□OUD - MAT
□OUD - Waiver to dispense bupreonrphine
□OUD - OBOT (Office Based OTP)
□OUD - Other: ____

Languages Spoken by Provider (Select all that apply):	Spanish ☐ Hindi ☐ Arabic ☐ Farsi ☐ American Sign Language ☐ Chinese ☐ Tagalog ☐ Interpretation Services Available? ☐	Languages Spoken by Office Staff (Select all that apply):	Spanish ☐ Hindi ☐ Arabic ☐ Farsi ☐ American Sign Language ☐ Chinese ☐ Tagalog ☐
Group Billing Name:	Group Tax ID#:	Group NPI#:	Number of Providers in Group:
Clearinghouse:	Availity ☐ Change Healthcare ☐ Trizetto ☐ Relay Health ☐	Payment Method (Select all that apply): Direct Deposit (EFT) ☐ ERA ☐	

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Mid-Level Practitioner
SUPERVISING PHYSICIAN RECOMMENDATION
FORM

Name of Applicant:______________________________

Degree (Advanced Practice Nurse-NP/CRNA/CNM and Physician Assistants-PA)**:**
____

CHC Participating Supervising Physician:

Name: ______________________________ Specialty: ____________________

NPI:
____

Delegation Location Type: ____Primary Practice Site ____Alternate Practice Site **Prescriptive Authority**

Supervision? _____Yes ____No

Job responsibilities and duties performed (i.e. histories, physicals, hospital rounds, assist in surgeries, etc.):

____
____
____
____

How are applicant's patients admitted? __________________________________
____
____
____

I attest that I am familiar with the applicant's qualifications, character, current clinical competence, health status and believe that he/she is qualified to provide care to CHC's members. I understand that to be a supervising/collaborating physician for applicant, I must participate in CHC's network. I further agree to supervise applicant's patient care as required.

_____________________________________ ______________________

Signature of Supervising Physician Date

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New Physician/Practitioner Required Documents

Please provide the following documents when submitting the Network Interest Form
CHC.Contracting@CommunityHealthChoice.org .

Request for participation cannot be processed until all required documents are received.

Physician/Practitioner Required Documents

- Participation Criteria Attestation Form
- Physician/Practitioner Network Interest Profile Form
- Current W-9
- Supervising Physician Form (must be in network provider)
- Area of Coverage Form (AOC)-LTSS Providers Only