COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Provider/Practitioner Profile Form

Criteria	Yes	No
Attested NPI	☐	☐
THSteps Provider (PCP only)		
Medicare Number		
Medicaid Number		
Not on Government Exclusion List?	☐	☐
EDI/EFT	☐	☐
EFT	☐	☐
After Hours Answering Service?	☐	☐

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.

Provider Printed Name	
Provider Signature	

Participating Group Adding New Provider?	**Yes** ☐	**No** ☐
New Group Requesting To Join Network?	**Yes** ☐	**No** ☐

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Programs	
STAR	☐
CHIP	☐
CHIP-Perinate	☐
STAR+PLUS	☐
D-SNP	☐
Marketplace	☐
Group Name	
Group Tax ID #	
Group NPI #	
Number of Providers in Group?	

Provider Information			
Provider Name		Degree	
NPI #		CAQH #	
Date of Birth (MM/DD/YYYY)		Gender	
PCP ☐	Specialist ☐	Hospital Based ☐	Behavioral Health ☐
Primary Specialty			
Secondary Specialty			
Supervising Physician Name (Mid-levels only)			
Supervising Physician NPI Number			

Practice Information

Street Address 1:			
Street Address 2:			
City:			
State:		Zip Code	
Phone:		Fax:	
County:			

Practice Accessibility Information (ADA Compliance)				
Building?	Yes	☐	No	☐
Parking?	Yes	☐	No	☐
Restrooms?	Yes	☐	No	☐

Office Hours		
Day	Open	Close
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Age Limits	From:	To:

Gender Restrictions	
Language Information	
Language	**Select All That Apply**
English	
American Sign Language	
Arabic	
Chinese	
Farsi	
Hindi	
Spanish	
Vietnamese	

Submitter Name		
Submitter Email		
Submitter Phone #		
Submitter Fax #		

A separate form must be completed for each provider. Attach a separate sheet with additional practice locations. Complete form in its entirety and return with a W-9 to **CHC.Contracting@CommunityHealthChoice.org**. Incomplete forms will not be processed.