



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	Indicate Criteria Met	Comments
Regulatory	Valid Texas Medicaid Number			N/A		
	Attested NPI Number			N/A		
	Medicare Number <i>(required)</i>					
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call					
	Not currently on Govt. Exclusion List					
	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			
Administrative	Submission of authorization requests via Provider Portal					
	Existing Clearinghouse Partnership					
	EDI - Electronic Claims Submission				Change Healthcare Availity Relay Health Trizetto	
	EDI - Electronic Funds Transfer					
	EDI - Electronic Remittance Advice					
Adherence to HIPAA Standard Transactions						

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

Home Community Support Services Agency (HCSSA) License Number

NPI	TIN	Medicare #	Medicaid #
Contact Person		Title:	
Email		Phone:	Fax:
Mailing Address		City	ST Zip

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

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Austin | <input type="checkbox"/> Matagorda |
| <input type="checkbox"/> Brazoria | <input type="checkbox"/> Montgomery |
| <input type="checkbox"/> Chambers | <input type="checkbox"/> Newton |
| <input type="checkbox"/> Fort Bend | <input type="checkbox"/> Orange |
| <input type="checkbox"/> Galveston | <input type="checkbox"/> Polk |
| <input type="checkbox"/> Hardin | <input type="checkbox"/> San Jacinto |
| <input type="checkbox"/> Harris | <input type="checkbox"/> Tyler |
| <input type="checkbox"/> Jasper | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Jefferson | <input type="checkbox"/> Waller |
| <input type="checkbox"/> Liberty | <input type="checkbox"/> Wharton |

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

- | | |
|--|--|
| <input type="checkbox"/> Adaptive Aids/Medical Supplies/Durable Medical Equipment Supplies (DME) | <input type="checkbox"/> Personal Attendant Services (PAS) |
| <input type="checkbox"/> Adult Foster Care | <input type="checkbox"/> Personal Care Assistant |
| <input type="checkbox"/> Assisted Living & Residential Care Services | <input type="checkbox"/> Private Duty Nursing (PDN) |
| <input type="checkbox"/> Consumer Directed Services (CDS) Agency | <input type="checkbox"/> Respite Care (facility based) |
| <input type="checkbox"/> Day Activity and Health Services (DAHS) | <input type="checkbox"/> Respite Care (in-home) |
| <input type="checkbox"/> Emergency Response Services (ERS) | <input type="checkbox"/> Support Management |
| <input type="checkbox"/> Adult Foster Care | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Consumer Directed Services (CDS) Agency | <input type="checkbox"/> Therapy - Occupational |
| <input type="checkbox"/> Minor Home Modification | <input type="checkbox"/> Therapy - Physical |
| <input type="checkbox"/> Financial Management Services (FMS) (CDS only) | <input type="checkbox"/> Therapy - Speech |
| <input type="checkbox"/> Habilitation Services | <input type="checkbox"/> Home Delivered Meals |
| <input type="checkbox"/> Flexible Family Supports | <input type="checkbox"/> 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	TUE	WED	THU	FRI	SAT	SUN	HOLIDAYS
Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	

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

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

Alternate Address

Address Location Name:

Phone:

Fax:

City:

State:

Zip:

Bus Route: Yes No

Walk-ins Accepted: ☐ Yes ☐ NoElectronic Medical Records: ☐ Yes ☐ No**Operating Hours (Ex: Mon-Fri 8am-5pm)**

MON	TUE	WED	THU	FRI	SAT	SUN	HOLIDAYS
Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	

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

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

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