COMMUNITY HEALTH CHOICE

LTSS/BH 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. If there is a criteria element that your business does not meet, please provide a relevant comment related to any future efforts in that category.

Criteria Type	Criteria	Medicaid	CHIP	Health Insurance Marketplace	Notes	Indicate Criteria Met	Comments
Regulatory	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 CFR482.43.	N/A	N/A	Yes		□	
Administrative	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 will acknowledge receipt of request within 10 business days. 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 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 any and all applicable authorization requirements.

LTSS/BH ANCILLARY NETWORK INTEREST PROFILE FORM

Please complete this form in its entirety and return with a copy of **W-9 to**
CHC.Contracting@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# _____

LICENSE # _____ Medicare# _____ Medicaid# _____

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

Contact Person: Title:

Email: Phone: Fax:

Mailing Address: City: ST: Zip Code:

Please check the type of LTSS service(s) you provide:

☐ Adaptive Aids	☐ Adult Foster Care (Agency)	☐ Adult Foster Care (Facility)
☐ Attendant Care	☐ Cognitive Rehab Therapy	☐ Dietitian/Nutritional Services
☐ Durable Medical Equipment	☐ Employment Assistance	☐ Employment Response Services
☐ Financial Management Services (FMS)	☐ Flexible Family Support	☐ Habilitation
☐ Home Delivered Meals	☐ Personal Attendance (PAS)	☐ Physical Therapy (PT)
☐ Private Duty Nursing (PDN)	☐ Respite Care	☐ Speech Therapy
☐ Support Management	☐ Therapy-Occupational	☐ Therapy – In-home Physical

Please check the Behavioral Health Provider type and any Opioid Use Disorder (OUD) service(s) you provide:

☐ Addiction Specialists	☐ MAT	☐ Opioid Treatment Program (OTP)
☐ SBIRT	☐ Prescribers of Medications for (OUD)	☐ Waiver to dispense Buprenorphine
☐ OBOT (Office Based OTP)	☐ Non-Local Mental Health Authority	☐ Local Mental Health Authority (LMHA)
☐ Applied Behavioral Analysis (ABA)		☐ Chemical Dependency Treatment Facility (CDTF)
	☐ OTHER:	

Service Location Information

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
☐ American Sign Language ☐ Spanish ☐ Vietnamese ☐ Other:

Patient Age Range: ☐ 0-18 ☐ 6-18 ☐ 18-99 ☐ Other:

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