BEHAVIORAL HEALTHCARE PROFESSIONAL NETWORK INTEREST PROFILE FORM

COMMUNITY HEALTH CHOICE

Please complete this form in its entirety and return with a copy of **W-9** by
Email to CHC.Contracting@CommunityHealthChoice.org.
Incomplete forms ***not*** considered.

Today's Date	☐ **Participating Provider already in the network, but would like to participate in additional program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **Marketplace**
	☐ **Provider NOT in the network, but would like to participate in the following program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **Marketplace**

PHYSICIAN OR HEALTHCARE PROFESSIONAL INFORMATION

Desired role: ☐ **BEHAVIORAL HEALTH PROVIDER**

Provider Name:

Primary Specialty: **Board Certified:** ☐ **Yes** ☐ **No**

Secondary Specialty: **Board Certified:** ☐ **Yes** ☐ **No**

CAQH Number:
(please use this time to re-attest and update your credentialing documents)

Licensure(s)

Individual NPI: **Medicare #:** **Medicaid #:**

If NP or LPA, name of supervising physician: **Supervising physician's NPI:**

Provider Contact Person **Contact Phone:**

Contact Email: **Contact Fax:**

Contact Mailing Address

City, State, Zip:

BILLING INFORMATION

Provider / Group / Billing Name:

Tax ID: **Group NPI:**

Is provider joining an existing group of providers who is currently participating with Community? ☐ **Yes** ☐ **No**

Clearinghouse: **Medicaid/CHIP:** ☐ **Availity** ☐ **Change Healthcare** ☐ **Trizetto**

Marketplace: ☐ **Change Healthcare**

Payment Method: ☐ **Direct Deposit (EFT)** ☐ **ERA**

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Service Location Information

Provider's Practice 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. – 7p.m.) **Sun:**_____ **Mon:**_____ **Tue:**_____ **Wed:**_____

Thu:_____ **Fri:**_____ **Sat:**_____ **Holidays:**_____

Languages spoken: ☐ **Arabic** ☐ **Chinese-Cantonese** ☐ **Chinese-Mandarin** ☐ **Hindi**

☐ **Sign Language** ☐ **Spanish** ☐ **Vietnamese** ☐ **Other:** _____

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

BEHAVIORAL HEALTHCARE PROFESSIONAL INFORMATION

List all Individuals, Nurse Practitioners, and Mid-Levels at the location to be listed in the Provider Directory.
Upon credentialing verification, the provider specialty indicated will also be listed in the directory.
Copy this page to add additional providers.

PROGRAM PARTICIPATION INTEREST	NAME AND CAQH #	PROVIDER TYPE/ SPECIALTY OR STATUS	MEDICAID TPI	INDIVIDUAL NPI	TAX ID	MEDICARE #	PATIENT TYPE ACCEPTED	PATIENT AGE RANGE	LANGUAGE(S) SPOKEN
☐ Medicaid ☐ CHIP ☐ Marketplace	Name: __________ CAQH: __________	☐ Psychiatry ☐ Psychology ☐ Other: __________					☐ Children ☐ Adults	☐ 0-5 ☐ 5-18 ☐ 13-17 ☐ 18-99 ☐ Other: ______	
☐ Medicaid ☐ CHIP ☐ Marketplace	Name: __________ CAQH: __________	☐ Psychiatry ☐ Psychology ☐ Other: __________					☐ Children ☐ Adults	☐ 0-5 ☐ 5-18 ☐ 13-17 ☐ 18-99 ☐ Other: ______	
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☐ Medicaid ☐ CHIP ☐ Marketplace	Name: __________ CAQH: __________	☐ Psychiatry ☐ Psychology ☐ Other: __________					☐ Children ☐ Adults	☐ 0-5 ☐ 5-18 ☐ 13-17 ☐ 18-99 ☐ Other: ______	