COMMUNITY HEALTH CHOICE

Facility/Ancillary Provider Participation Criteria

Thank you for your interest in becoming a Participating Provider with the Community Health Choice Network. Community is focused on continuous monitoring of network adequacy, full transparency in communication, a staunch commitment to quality, and elimination of administrative burdens, amongst other items.

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 CFR 482.43.	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 Provider Review 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.

COMMUNITY HEALTH CHOICE

FACILITY/ANCILLARY NETWORK INTEREST PROFILE FORM

Please complete this form in its entirety and return with a copy of **W-9** by
fax **713-295-7058** or **email** 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** ☐ **CHIP Perinatal** ☐ **Marketplace**
	☐ **Provider NOT in the network, but would like to participate in the following program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **CHIP Perinatal** ☐ **Marketplace**

General Information

Legal Name:

Operating / DBA Name

NPI: **TIN:** **Medicare #:** **Medicaid #:**

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

Marketplace: ☐ **Change Healthcare** ☐ **Relay Health**

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

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Contact Person: **Contact Phone:**

Contact Email: **Contact Fax:**

Contact Mailing Address:

City, State, Zip:

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

☐ **Acute Hospital**	☐ **FQHC**	☐ **Physical Therapy**
☐ **Ambulance**	☐ **Home Health**	☐ **Speech Therapy**
☐ **Ambulatory Surgery Center**	☐ **Hospice**	☐ **Speech Therapy (CCP Provider)**
☐ **Behavioral Health**	☐ **Infusion**	☐ **Rural Health Clinic**
☐ **Critical Access Hospital**	☐ **Occupational Therapy**	☐ **Skilled Nursing Facility**
☐ **Dialysis**	☐ **Orthotics/Prosthetics**	☐ **OTHER:**
☐ **DME (please include list of ALL services/products)**	☐ **Pediatric Home Health**	

☐ **Diagnostics (please specify):**

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**
☐ **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.**

INTERNAL USE ONLY	
Received by:	**Received date:**