COMMUNITY HEALTH CHOICE

URGENT CARE Participation Criteria

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

Please take a moment to review the 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	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		☐	
Administrative	Internet Access - Office/Patient Care Setting	Yes	Yes	Yes		☐	
	Facsimile	Yes	Yes	Yes		☐	
	Electronic Medical Records	Yes	Yes	Yes		☐	
	Electronic submission of prescriptions (e-Prescribe)	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		☐	
Quality	Onsite services (i.e., lab, x-ray, etc)	Yes	Yes	Yes		☐	
	☐ Accreditation - Urgent Care Association of America (UCAOA) or ☐ Certification - Certified Urgent Care (CUC) Program					☐	
	Patient Satisfaction Measurement Tool	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.

NETWORK INTEREST PROFILE FORM – URGENT CARE

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 Urgent Care already in the network, but would like to participate in additional program(s):**	☐ **Medicaid** ☐ **CHIP** ☐ **CHIP Perinatal** ☐ **Marketplace**
	☐ **Urgent Care 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:

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

Service Address:

Primary Contact: **Phone Number:** **Fax Number:**

Medical Director Name: **NPI:**

Staffing Level: ☐ **MD only** ☐ **MD or DO** ☐ **MD and/or DO and Physician Extenders** ☐ **Physician Extenders with offsite supervision**

Onsite services (check all that apply):

- ☐ Administration of IM Medications
- ☐ Administration of IV Medications and Fluids
- ☐ Casting
- ☐ CLIA-certified Lab
- ☐ CLIA-waived lab
- ☐ EKG (with certified reading)
- ☐ Incision and drainage or cyst removal
- ☐ Laceration repair with sutures
- ☐ Phlebotomy
- ☐ Splinting
- ☐ X-Ray ☐ with certified radiologist

Equipment and Staff trained in its use (check all that apply):

- ☐ Automated External Defibrillator (AED)
- ☐ Crash cart
- ☐ Oxygen / Ambu-bag / Oral Airway

Is the Urgent Care Center accredited or certified?

- ☐ Urgent Care Association of America (UCAOA)
- ☐ Certified Urgent Care (CUC)

Number of Exam Rooms: _____

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: ☐ 0-3 ☐ 3-18 ☐ 18 + ☐ Other: _____

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

Billing Information

Provider Group / Billing Name:

Tax ID: **Group NPI:**

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

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