CHRISTUS Health Plans

PROSPECTIVE PROVIDER FORM

Please return this form with your W-9 to CHP.networkdevelopment@christushealth.org

Are you joining a Group that is already participating?
If yes, provide Group Name: _____

Networks Desired: ☐ **Medicare Advantage** ☐ **CHP/HIX** ☐ **USFHP**
Provider Type: ☐ **Physician/Allied Health** ☐ **Ancillary** ☐ **Hospital** ☐ **PHO** ☐ **IPA** ☐ **Group**

Facility/Ancillary Name: _____

Group Name _____

Last Name _____ First Name _____ MI ____ Degree _____

DBA Name _____

****Primary Service Address _____**

City _____ State ____ Zip _____ County _____

Phone _____ FAX _____ ****Provide list of all additional practicing locations*

Office Contact Name: _____ E-Mail Address: _____

Primary Specialty _____Secondary_____ Board Certification(s) Yes ☐ No ☐

Are you located in a Medically Underserved Area (MUA) Yes ☐ No ☐

NPI _____ Group NPI _____ Tax ID _____

Medicare # _____ CAQH # _____ Taxonomy _____

SSN#_____ DOB_____

Primary Admitting Hospital _____Secondary Hospital_____

Covering Physician Name: _____ Specialty: _____
Address_____

Phone: _____Email:_____

Applicants interested in network participation must meet the following qualifications:

- Have unrestricted admitting privileges at an in network participating facility. Additionally, providers practicing within 30 miles of a CHRISTUS Health facility must have admitting privileges at the CHRISTUS Health facility.
- Current, valid, unrestricted license to practice in the state in which they intend to provide services, free of sanctions, board orders, probation, restrictions and/or limitations, verified by the state licensing agency and disclose any history of loss of license or felony convictions.
- Maintain a valid and unrestricted DEA and CDS certificate issued in the state of practice for the prescription of controlled substances, where applicable to the specialty practiced.
- Board certified or have fulfilled the requirements needed to meet the time limits for certification from the specialty board of the provider's area of practice.
- Eligible to treat Medicare patients **(Required for participation in USFHP Only)**
- Not under investigation or suspension from participation in a federal or state health care program.
- Ability to meet access and availability standards and network adequacy needs
- Facility or ancillary provider, must have a current accreditation or an acceptable site visit; an appropriate licensure; a current Medicare/Medicaid certification status, current malpractice insurance coverage an acceptable malpractice history.
- **If we are unable to execute an agreement due to criteria not being met, a notification will be sent. Completing the credentialing process does not constitute participation in the health plan.**

NOTIFICATION OF APPLICANT RIGHTS

Dear Applicant:

During the Credentialing process, you have the right to:

1. **Correct erroneous information identified during the Credentialing process in your application**

2. **Upon request, to be informed of the status of the credentialing or recredentialing application**

3. **Review information that you have submitted to support your credentialing application**

If you have inquiries or questions during the credentialing process, please contact the CHRISTUS Health Credentialing Department at:

CHRISTUS Health Plan
US Family Health Plan
ATTN: Credentialing Department
919 Hidden Ridge
Irving, TX 75038
Phone: (469) 282-3019
FAX: (210) 766-8857
Email: christus.hp.credentialing@christushealth.org