

# CHRISTUS Health Plans

## PROSPECTIVE PROVIDER FORM

Please return this form with your W-9 to [CHP.networkdevelopment@christushealth.org](mailto: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](mailto:christus.hp.credentialing@christushealth.org)