Letter of Interest Questionnaire

Please complete the Provider Data Information Form (PDI) and return to Network Development by fax 682-885-8403 or email cchpnetworkdev@cookchildrens.org.

- A current W-9 form must be included with this form for processing.
- If this is a group, please attach a physician roster.

Provider Information

Provider Name: ______________________________

Primary Specialty: ______________ Secondary Specialty: ______________

Email Address: ______________________________

Practice Information

Individual ☐ Group ☐

Practice Name: ______________________________

Physical Address: ______________ City: ________ State: ______ Zip: ______

Phone Number: ______________ Fax Number: ______________

Tax Id Number: __________ NPI Number: __________ TPI Number: __________

Contact Name: ______________ Title: ______________

Contact Phone Number: ______________ Contact Fax Number: ______________

Contact Email Address: ______________________________

Billing Information

Billing Name: ______________________________

Physical Address: ______________ City: ________ State: ______ Zip: ______

Phone Number: ______________ Fax Number: ______________

Credentialing Contact

Contact Name: ______________ Title: ______________

Mailing Address: ______________ City: ________ State: ______ Zip: ______

Phone Number: ______________ Fax Number: ______________

Email Address: ______________ Hours Available: ______________

Type of Services Provided: ______________________________

____

Please check all that apply:

Accepting: ☐ Male ☐ Female

Age Restrictions: ☐ Yes ☐ No If yes, please explain:____________________

Panel Status: ☐ Open ☐ Closed ☐ Existing Only

Directory Print: ☐ Yes ☐ No

Do you treat: ☐ Children ☐ Adults ☐ Pregnant women

Languages Spoken: ____________________

Office Hours: ____________________

If you are a PCP do you provide EPSDT (Texas Health Steps) services? ☐ Yes ☐ No

Do you participate in the Vaccine for Children's (VFC) program? ☐ Yes ☐ No

Are you currently contracted with an Electronic Visit Verification (EVV) vendor? ☐ Yes ☐ No

If yes, please list the vendor name: ____________________

Do you provide: ☐ Telehealth ☐ Tele-monitoring ☐ Telemedicine

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Long –Term Services and Supports (LTSS)

☐ Child Group Care Home

☐ Assisted Living Home or Center

☐ Home Delivered Meals

☐ Minor Home Modification

☐ Personal Care Agency

☐ Hospice

☐ Pediatric Day Facility

☐ Personal Emergency Response System (Emergency Alert)

☐ Fiscal Intermediary (FI)

☐ Vehicle Modifications

☐ Habilitation Agency

☐ Medically Dependent Children Program (MDCP)

☐ PT/OT/ST

☐ DME

☐ Skilled Nursing

Specialized Therapies: ____________________

Other: ____________________

____________________ __________

Completed by Date