Cook Children's Health Plan

Letter of Interest Questionnaire

Please complete the Letter of Interest Questionnaire for each provider and return to Network Development by fax 682-885-8403 or email CCHPNetworkDevelopment@cookchildrens.org.

A current W-9 form must be included with this form for processing.

Provider Information

Organization Name: _____

Type of Services Provided: _____

Last Name: _____ First Name: _____

Date of Birth: _____ NPI or API: _____ TPI: _____

CAQH Number: _____

Primary Specialty: _____ Secondary Specialty: _____

Board Certified: Yes ❑ No ❑ If No, Completion Date of Residency: _____

Hospital Privileges: _____

Physician(s) for call coverage: _____

Practice Information

Facility ❑ Group ❑ Individual ❑

Practice Name: _____

Practice Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

Tax ID: _____ NPI or API: _____ TPI: _____

Contact Name: _____ Contact Phone: _____

Contact Email: _____

Mailing Information

Mailing Name: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Credentialing Information

Contact Name: _____ Title: _____

Phone: _____ Fax: _____

Contact Email: _____

Office Information

Panel status: Open ❑ Closed ❑ Existing only ❑

Age restrictions: Yes ❑ No ❑ If yes, please explain _____

Do you treat: Children ❑ Adults ❑ Pregnant Women ❑

Patients gender: Male ❑ Female ❑ Both ❑

Directory print: Yes ❑ No ❑

Languages spoken: _____ Interpreter ❑ Provider/Staff ❑

Office hours: _____ Extended hours: _____ Handicap accessible: Yes ❑ No ❑

Completed Cultural Competency Training Yes ❑ No ❑

If yes, fax or email attestation/certification to Network Development.

Office Information

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

Are you contracted with an Electronic Visit Verification (EVV) vendor?

Yes ❑ No ❑ If yes, please list vendor name: _____

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

Long Term Services and Supports (LTSS)

- ❑ Adaptive Aides / Medical Equipment (DME)
- ❑ Adult Day Care/Day Activity and Health Services
- ❑ Adult Foster Care
- ❑ Assisted Living/Residential Care/Group Home
- ❑ Emergency Response System
- ❑ Employment Assistance
- ❑ Flexible Family Support Services
- ❑ Financial Management Service (FI) (CDS)
- ❑ Habilitation (PAS/HAB) (CFC)
- ❑ Home & Community Support Services (HCSSA)
- ❑ Home Delivered Meals
- ❑ Hospice
- ❑ Medically Dependent Children Program (MDCP)
- ❑ Minor Home Mods
- ❑ Nursing Facility
- ❑ Occupational Therapy
- ❑ Personal Assistance Services (CFC)
- ❑ Personal Assistance Services/Personal Care Services/Attendant Care/Primary Home Care (Agency Model)
- ❑ Personal Assistance Services/Personal Care Services/Attendant Care/Primary Home (Service Responsibility Option)
- ❑ Prescribed Pediatric Extended Care Centers (PPECC)
- ❑ Physical Therapy
- ❑ Private Duty Nursing (PDN)
- ❑ Respite Care (In Home)-Personal Assistance Service
- ❑ Respite Care (In Home)-Nursing
- ❑ Respite Care (Facility)
- ❑ Skilled Nursing
- ❑ Speech Therapy
- ❑ Supported Employment
- ❑ Transition Assistance Services
- ❑ Vehicle Mods Specialized
- ❑ Other: _____

Counties Served: _____

Completed by: _____ Date: _____

SUBMIT REQUEST

When the credentialing process is initiated for practitioners and organizations, the applicant is entitled to:

1. Review the information submitted to support their credentialing application
2. Correct erroneous information
3. Receive the status of their credentialing or recredentialing application, upon request.

Email CCHPNetworkDevelopment@cookchildrens.org with any questions or concerns.