Driscoll Health Plan
TEXAS STANDARDIZED CREDENTIALING APPLICATION ADDENDUM
(Other Requested Information)

All information contained on this form is for DHP use only and will be held in a CONFIDENTIAL File

Last First Middle

Provider Name:

Social Security Number: Professional License number:

CAQH Provider ID: Provider Date of Birth:

Provider TPI: Provider NPI:

Please mark the ethnic background that best describes you:

_____White, non-Hispanic _____Hispanic _____ Asian, Pacific Islander

_____Black, non-Hispanic _____American Indian or Alaskan _____Unknown/Other

Are you applying to be a participating:

_____Primary Care Physician _____Specialist Physician _____ Both

_____Allied Health Professional (Licensed, certified, registered, or otherwise authorized non-physician providers of direct patient care services)

Are you a Family Practice Provider applying as a PCP? ____Yes ___No

Are you a General Practice Provider applying as a PCP? ____Yes ____No

If yes, do you perform OB services? ___ Yes ___No

If yes, do you perform OB deliveries? ___ Yes ___No

If you are applying to be a Primary Care Provider (PCP) do you meet the following requirements? _____Yes _____No

If no, please provide explanation:

_____

_____

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PCP Requirements:

- Must be available to membership twenty-four (24) hours a day, seven (7) days a week
- Must have call coverage with providers who are credentialed through DHP
- Must be a Texas Health Steps provider (for STAR/Medicaid and STAR Kids members) and follow the Texas Health Steps periodicity schedule – unless provider is limited to adult members, only.
- Must be a participant in the Vaccines for Children program unless provider is limited to adult members only
- Must follow the American Academy of Pediatrics periodicity schedule (for CHIP members) – unless provider is limited to adult members, only.
- Must be a participant in the Vaccines for Children program - unless provider is limited to adult members, only.
- Must have hospital admitting privileges
- Must pass the provider office site visit, with an 85% score or better
- Must have acceptable after-hours availability
- Must assess member needs and make appropriate specialty referrals as needed. PCP must coordinate member's care with the specialty care provider after referral

A Specialist may be a Primary Care Provider (PCP), as long as they meet the requirements stated above. If you are a Specialist applying to be a Primary Care Provider (PCP) do you meet the requirements? _____Yes _____No

If no, please provide explanation:

_____

_____

Mid-Level Professional (PA, NA, FNP, etc.)

Please complete the section below if you are a **Mid-Level Professional (PA, NP, FNP, etc.):**

Title:_____

Are you applying to be a participating Primary Care Provider?____Yes ___No

Hospital Privileges? ___Yes ___No (If no, Please provider explanation of hospital admissions process)

Supervised by Physician? ___Yes ___No or Stand Alone? ____Yes ___No

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% Time Supervised:_____

Name of Supervising Physician:_____
(*Attach copy of Prescriptive Authority Agreement or Collaborating Agreement)*

Supervising Physician Specialty: _____

Is Supervising Physician credentialed with Driscoll Health Plan? ___Yes ___No

Protocols in place and available for site review? ___Yes ___No

Practice Information

Group TPI:	Group NPI:
Are you a TH Steps (EPSDT) Provider? ___Yes ___No If Yes, TH Steps Provider#:_____ (EPSDT is a Federal program for Medical Assistance recipients, providing periodic screening to patients under 21 years)	Tax ID Number: _____
CLIA License: ___Yes ___No If yes, exp. Date: (*Please attach a copy*)	If no lab or x-ray service in your office, what is the existing referral process? Lab: X-Ray:

For Telehealth Services please indicate if you provide:
Telehealth_____ Telemed _____ Both _____ or none _____

To assure that your authorization/referral replies are going to the correct office fax number please provide below:

Office Fax Number for authorization/referrals: _____