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
Name:		

Social Security Number: TX License Number:

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)

Please complete for Mid Level Professionals (PA, NP, FNP, etc.):

Title:_____

Are you applying to be a participating Primary Care Provider? ☐ Yes ☐ No

Hospital Privileges? ☐ Yes ☐ No (If No, Please provide explanation of hospital admissions process.)

Supervised by Physician? ☐ Yes ☐ No or Stand Alone? ☐ Yes ☐ No

% Time Supervised:_____

Name of Supervising Physician :_____

Supervising Physician Specialty:_____

Is Supervising Physician credentialed with Driscoll Health Plan? ☐ Yes ☐ No

Protocols in place and available for site review? ☐ Yes ☐ No

Provider TPI:	Provider 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:

Practice Information
(Please complete for each location.)

Does your office(s) have: Lab Service: ☐ Yes ☐ No X-ray Service: ☐ Yes ☐ No (If yes, please attach a copy)	Do you perform surgeries in your office(s)? ☐ Yes ☐ No *(If yes, please list the types of surgery)*
CLIA License: ☐ Yes ☐ No If yes, exp. date: (Please attach a copy)	If no lab or x-ray service in your office, what is existing referral process? Lab: X-ray: