



For internal use only			
<input type="checkbox"/> CA1	<input type="checkbox"/> B	<input type="checkbox"/> 1	<input type="checkbox"/> 6
		<input type="checkbox"/> 2	<input type="checkbox"/> 7
	<input type="checkbox"/> O	<input type="checkbox"/> 3	<input type="checkbox"/> 8
		<input type="checkbox"/> 4	<input type="checkbox"/> 9
	<input type="checkbox"/> G	<input type="checkbox"/> 5	<input type="checkbox"/> 10

## Letter of Interest Questionnaire

This form may supplement, or replace, a letter of interest for our provider network. Please answer the following questions. This information will help us in assessing your qualifications with the service needs of our network. Once completed, please fax to 832-825-8750, Attn: LOI Committee. For questions, call 832-828-1008.

### Demographic Information

Name: \_\_\_\_\_

Is this a group practice? \_\_\_\_\_ Group name: \_\_\_\_\_

Service address: \_\_\_\_\_ Zip code \_\_\_\_\_

Billing address: \_\_\_\_\_ Zip code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Tax ID number: \_\_\_\_\_

NPI number: \_\_\_\_\_ (required) Group NPI number: \_\_\_\_\_

TPI number: \_\_\_\_\_ (required) THSteps TPI number: \_\_\_\_\_

Specialty: \_\_\_\_\_

### Provider Service Information

1) What services do you provide?  
 \_\_\_\_\_  
 \_\_\_\_\_

2) What is unique about the services you provide? What languages are spoken in your office?  
 \_\_\_\_\_  
 \_\_\_\_\_

3) Will you accept both STAR and CHIP members/patients?  Yes  No

4) Will you accept CHIP Perinate members/patients?  Yes  No

5) Do you treat  Children  Adults  Pregnant women

6) What are your hours of operation? \_\_\_\_\_

7) If you are a behavioral health provider do you provide home visits?  Yes  No

8) If you are a PCP do you provide EPSDT services?  Yes  No

9) Do you participate in the VFC program?  Yes  No

10) What other Medicaid and CHIP plans are you enrolled?  
 \_\_\_\_\_  
 \_\_\_\_\_

11) Which hospitals do you have admitting privileges?  
 \_\_\_\_\_  
 \_\_\_\_\_

12) List counties served. \_\_\_\_\_

**Important: Please include your W-9 form with this questionnaire.**