Parkland
Community Health Plan

Prospective Provider Form

Thank you for your interest in becoming a Parkland Community Health Plan Provider. Please complete this form and email to **PCHP.ContractingDepartment@phhs.org**.

Attach a copy of Current W9 and Sample Claim.
Adding provider to an existing group?   YES   NO

Signatory Name	Signatory Title	Signatory Email
Requester Name	Date Requested	Requester Email

Group Name	Group TIN(s)	Group NPI(s)

Is your Practice a PCMH? YES NO	Do you have Electronic Medical Records? YES NO	Do you provide services in an outpatient setting? YES NO

Practitioner Information

First Name	Last Name	MI	Degree

Provider NPI #	Tax ID #	Social Security #	Provider Specialty	Practice as PCP Specialist Both

Gender Male Female	Race/Ethnicity	Taxonomy Code	DOB

Individual CAQH	License #	Attested with Medicaid YES NO	Language(s)

Appear in Directory YES NO	Age Range	Gender Restrictions Female Male None	Accepting New Members YES NO

Board Certifications	Panel Cap (#)	Offers Telemedicine YES NO	Hospital Based Provider YES NO

Hospital Affiliation – List Name(s)	Hospital Admitting Privileges – List Name(s)

Provider Enrollment type per TMHP Individual Group Performing Provider Facility	Completed HHSC's training on Culturally Effective Health Care? YES NO

Physical Address / Primary Location – Additional Locations, please email PCHP.ContractingDepartment@phhs.org

Service Location Name	Service Location Website	Service Location Email

Street Address	City	State	Zip Code	County	Handicap Accessible YES NO

Phone	Fax	Office Hours for Location Above:	24/7	Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.

Billing / Mailing / Remit Information – Same as Physical Address/Primary Location?   Yes

Billing Name Information	Billing Type CMS 1500 UB04 Both	Billing Email

Street Address	City	State

Zip Code	County	Phone	Fax

Credentialing

Credentialing Contact Name	Credentialing Email	Credentialing Phone	Credentialing Address

Please submit to **PCHP.ContractingDepartment@phhs.org**