



State Managed Care Network
NEW PROVIDER CONTRACT QUESTIONNAIRE

The purpose of this questionnaire is to have the most accurate and up-to-date information to ensure you receive reimbursement in a timely manner. Please complete and return this questionnaire with your signed contracts. Feel free to submit a roster of your physicians or use additional paper if necessary. Thank you!

Practice Information

Legal Name (as it appears on your W-9):

Common Name or "d.b.a.":

Tax Identification Number (TIN):

Contract type: Primary Care, Specialty, Ancillary, Hospital, Network, ER, Ambulance, Specialty-Behavioral Health, Hospital-Behavioral Health, MHC, RTC

Billing Address:

Mailing Address:

Phone Number:

Phone Number:

Fax Number:

Fax Number:

Website Address:

Email Address:

Administration Information

Please list contacts for your practice to ensure clear communication about claims, policies and procedures.

Administrator:

Phone:

Office/Business Manager:

Phone:

Billing/Claims:

Phone:

Referral Coordinator:

Phone:

Executive Director:

Phone:

Other:

Phone:

Service Locations

Primary Practice Location Address:

Secondary Practice Location Address:

Address lines for Primary Practice Location

Address lines for Secondary Practice Location

Phone Number:

Phone Number:

Fax Number:

Fax Number:

County:

County:

Available 24/7? Community Health Center?

Available 24/7? Community Health Center?

Clinical Staff & Credentialing Information (For Primary Care and Specialty Providers Only)

Please list the following information for all health care providers who could have CHP+ members assigned to them as their Providers. For additional clinical staff, attach copies of this form.

Name (first, last, & mi): _____ Degree Type: _____ National Provider ID #: _____
 DOB: _____ Gender: _____ Specialty: _____ Languages Spoken: _____
 Medical License Number: _____ Expiration Date: _____
 DEA License Number: _____ Expiration Date: _____
 Board Certified Provide Pre-Natal Care Provide OB Care
 Malpractice Insurance Coverage Date Span: _____
 List all hospitals where new provider has admitting privileges: _____

Insurance Carriers Accepted: CO Access Denver Health Kaiser Rocky Mtn HMO
 Age Groups Accepted: Child Teen Adult Patient Choice: New Existing Patients
 Service Locations: _____

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 DOB: _____ Gender: _____ Specialty: _____ Languages Spoken: _____
 Medical License Number: _____ Expiration Date: _____
 DEA License Number: _____ Expiration Date: _____
 Board Certified Provide Pre-Natal Care Provide OB Care
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 List all hospitals where new provider has admitting privileges: _____

Insurance Carriers Accepted: CO Access Denver Health Kaiser Rocky Mtn HMO
 Age Groups Accepted: Child Teen Adult Patient Choice: New Existing Patients
 Service Locations: _____

Ancillary Information (For Ancillary Providers Only)

<p>Diagnostic Medical Services</p> <p><input type="checkbox"/> Diagnostic Radiology</p> <p><input type="checkbox"/> Lab Analysis</p> <p><input type="checkbox"/> X-Ray</p> <p><input type="checkbox"/> Other _____</p> <p>Professional Services</p> <p><input type="checkbox"/> IV</p> <p><input type="checkbox"/> Other _____</p>	<p>Durable Medical Equipment</p> <p><input type="checkbox"/> Beds</p> <p><input type="checkbox"/> Bili Lights</p> <p><input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Nebulizers</p> <p><input type="checkbox"/> Orthopedic Appliances</p> <p><input type="checkbox"/> Oxygen</p> <p><input type="checkbox"/> Prosthesis</p> <p><input type="checkbox"/> Wheelchairs</p> <p><input type="checkbox"/> Other _____</p>
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Credentialing Documentation Required for Primary Care and Specialty Care (including Behavioral Health) Providers (this includes providers with individual contracts or providers attached to Network contracts)

If you currently participate with CAQH, please ensure that your CAQH record and supporting documentation are up to date. If you are not currently participating with the CAQH, please contact the Colorado Access credentialing staff at 720.744.5100 or toll free at 800.511.5010 and they will assist you.

Credentialing Documentation Required for Facilities

If you currently participate with CAQH, please ensure that your CAQH record and supporting documentation are up to date. If you are not currently participating with the CAQH, please contact the Colorado Access credentialing staff at 720.744.5100 or toll free at 800.511.5010 and they will assist you.

Hospitals/Facilities/Ancillary Providers must provide copies of the following:

- Current State of Colorado Hospital License
- Proof of Malpractice Coverage/Liability Coverage
- W-9 Taxpayer Identification Form (W-9 must match the name of the contract holder (legal name) and corresponding Taxpayer Identification Number (TIN))

Credentialing Documentation Required for ER Physicians and Ambulance Providers

If you currently participate with CAQH, please ensure that your CAQH record and supporting documentation are up to date. If you are not currently participating with the CAQH, please contact the Colorado Access credentialing staff at 720.744.5100 or toll free at 800.511.5010 and they will assist you.

ER Departments and Ambulance Providers must provide copies of the following:

- Any applicable State licenses or certificates
- Proof of Liability Insurance
- W-9 Taxpayer Identification Form (W-9 must match the name of the contract holder (legal name) and corresponding Taxpayer Identification Number (TIN))

Provider Questionnaire Completed by: _____
Date: _____