TDI | Texas Department of Insurance

LHL234f | 0107

Texas Standardized Credentialing Application

Attachment F – Other Practice Locations

Practice location information - Please answer the following questions for each practice location. Use Attachment F or make copies of page 3 as necessary.

Practice location of

Type of service provided
☐ Solo primary care ☐ Solo specialty care ☐ Group primary care ☐ Group single specialty ☐ Group multi-specialty

Group name/practice name to appear in the directory	Group/Corporate name as it appears on IRS W-9

Practice location address
☐ **Primary**

City	State/Country	Postal code

Phone number	Fax number	Email

Back-office phone number	Site-specific Medicaid number	Tax ID number

Group number corresponding to tax ID number	Group name corresponding to tax ID number

Are you currently practicing at this location? ☐ Yes ☐ No	If no, expected start date? (mm/dd/yyyy)	Do you want this location listed in the directory? ☐ Yes ☐ No

Office manager or staff contact	Phone number	Fax number

Credentialing contact

Address

City	State/Country	Postal code

Phone number	Fax number	Email

Billing company's name (if applicable)	Billing representative

Address

City	State/Country	Postal code

Phone number	Fax number	Email

Department name if hospital-based	Check payable to	Can you bill electronically? ☐ Yes ☐ No

Hours patients are seen

Monday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Tuesday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Wednesday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Thursday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Friday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Saturday	☐ no office hours	morning: _____	afternoon: _____	evening: _____
Sunday	☐ no office hours	morning: _____	afternoon: _____	evening: _____

Does this location provide 24-hour/7-day-a-week phone coverage?
☐ Answering service ☐ Voicemail with instructions to call answering service ☐ Voicemail with other instructions ☐ None

This practice location accepts:
☐ All new patients ☐ Existing patients with change of payor ☐ New patients with referral ☐ New Medicare patients ☐ New Medicaid patients

If new patient acceptance varies by health plan, please provide explanation.

Practice limitations

☐ male only ☐ female only age: ☐ other:

Do nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients at this practice location?

☐ Yes ☐ No if Yes, provide the following information for each staff member:

Name	Professional designation	State and License number
Name	Professional designation	State and License number

Attachment F (continued)

Practice location information - continued

Name	Professional designation	State and license number
Name	Professional designation	State and license number
Name	Professional designation	State and license number
Name	Professional designation	State and license number

Non-English languages spoken by health care providers

Non-English languages spoken by office personnel

Are interpreters available?
☐ Yes ☐ No if Yes, please specify languages:

Does this practice location meet ADA accessibility standards?
☐ Yes ☐ No

Which of the following facilities are handicapped accessible?
☐ building ☐ parking ☐ restroom ☐ other:

Does this location have other services for the disabled?
☐ Text telephony-TTY ☐ American Sign Language (ASL) ☐ Mental/physical impairment services ☐ Other:

Is this location accessible by public transportation?
☐ Bus ☐ Regional train ☐ Other:

Does this location provide childcare services?
☐ Yes ☐ No

Does this location qualify as a minority business enterprise?
☐ Yes ☐ No

Who at this location have the following current certifications? (please list only the applicant's certification expiration dates)

Basic Life Support	☐ Staff	☐ Provider Exp: _____	Advanced Life Support in OB	☐ Staff	☐ Provider Exp: _____
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp: _____	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp: _____
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp: _____	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp: _____
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp: _____	Other (specify): _____	☐ Staff	☐ Provider Exp: _____

Does this location provide any of the following services on site? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

Does this location provide any of the following services on site? ☐ Yes ☐ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies

☐ Other:

Please list any additional office procedures provided (including surgical procedures)

Is anesthesia administered at this practice location?
☐ Yes ☐ No Please specify the classes or categories:

Who administers it?

☐ Please check this box and complete and submit Attachment F if you have other practice locations.