Request Form to Join the Community Health Options Provider Network

Thank you for your interest in becoming a participating provider in Community Health Options' Provider network. If you'd like us to consider your practice/facility, please complete this form and email it to the Community Health Options Contracting Department at contracting@healthoptions.org.

We will respond within 90 days upon receipt of your completed form. This form will assist your contract manager in assessing your candidacy as a Community Health Options participating provider. Please refer to the last page of this form for more details about our process.

Please complete the following information:

Are you currently providing care to a Community Health Options Member or a Member awaiting care?
☐ Yes ☐ No

If awaiting care, what is the Member's appointment date? ___________________________________

Provider Legal Name (as on W-9): ____

Provider DBA Name: ____

Provider address:____State: _____________ Zip: _________

Telephone: _______________________________ Fax#: ____

Tax ID#: _________________________________Group NPI#: ____________________________________

Provider Website: ____

Provider/Group Specialty Type:

☐ Primary Care (PCP)	☐ DME / O&P	☐ Free Standing ASC
☐ PA as PCP	☐ Infusion Center	☐ ER Physicians
☐ Specialist	☐ Imaging Center	☐ Ambulance
☐ PT/OT/ST	☐ Urgent Care	☐ Sleep Center
☐ Chiropractor	☐ Lab	☐ Anesthesia/CRNA
☐ Acupuncture	☐ Home Health/Hospice	☐ Behavioral Health
☐ Audiology/Hearing Aid	☐ SNF/LTC	☐ Other ___________

Request Form to Join the Community Health Options Provider Network

Does provider perform **telehealth** services? ☐ Yes ☐ No

Is provider telehealth ***only*** (i.e., does not have a physical practice location)? ☐ Yes ☐ No

*List top 6 CPT/HCPCS/Rev service codes: _______ _______ ________ _______ _______ ________

Which claim form will be used to submit claims? ☐ UB ☐ HCFA 1500 ☐ Both

Is practice owned or employed by a Hospital System? ☐ Yes ________________________ ☐ No

Is provider/practice affiliated with a PHO, ACO, IPA or ASO? ☐ Yes ______________________ ☐ No

Are Surgeries performed on site? ☐ Yes ☐ No

Are Labs performed on site? ☐ Yes ☐ No If no, company name: ________________________________

Are imaging services performed on site? ☐ Yes ☐ No If no, company name: ________________________

Does provider use a third-party credentialing company? ☐ Yes _______________________ ☐ No

Does provider use a third-party claims vendor (TPA)? ☐ Yes _______________________________ ☐ No

Contracting Contact Name : ___________________________ *Title:* _________________________

Contact Email Address: ___________________________________

Contract Signatory Name: __________________________ *Contract Signatory Title:* ___________________

Signatory Email Address: ______________________________

Contact name for Payor Notices: ____

Provider Notice Address: _____________________________________ *Same as location* ☐

Request Form to Join the Community Health Options Provider Network

Contracting Process

1) Complete the **Provider Request to Join Network** and submit to contracting@healthoptions.org

2) Community Health Options' contract manager will review your information based on network need and proposed rates for the services that you or your practice provides.

3) If network need is determined, than a contract proposal will be extended for review and approval, with a request for the required credentialing documents listed below:

- Practice Information Form
- Credentialing Form or Provider Roster
- W9
- Copy of Certificate of Professional and/or Commercial Liability Insurance ($1,000,000/ $3,000,000)
- Licensure/Board Certification
- DEA License (if applicable)
- Facility Assessment Form (if applicable)
- Accreditation (if applicable)

Documents will need to be returned via email to contracting@healthoptions.org or fax to 207-520-6244 before the process can move forward.

4) Once both parties agree to the contract, it will be executed by the Community Health Options Director in DocuSign and forwarded for counter-execution through the same platform.

5) If network participation is denied, the provider will be notified either via email or letter.

Contracting Prerequisites

Providers who require credentialing must have a signed contract with Community Health Options, or an agreement with an entity that is actively contracted, before the credentialing process can begin. Providers cannot provide services to Community Health Options Members until the credentialing committee approves them for network participation. Any claim submitted prior to the effective date of the network participation could be denied.