CHOC HEALTH ALLIANCE

LETTER OF INTEREST QUESTIONNAIRE

Type or print legibly. If you need extra space to complete the fields below, please attach a separate sheet of paper.

Organizational Provider:

Primary Specialty: **Subspecialty:**

Office Address:

Office Telephone: **Office Fax:**

Office Manager's Name:

Office Manager's E-mail:

Individual NPI: **Group NPI:**

1. Pediatric specialty or focus?	☐ Yes	☐ No
2. Actively Enrolled in Medi-Cal Program (California Department of Health Care Services)?	☐ Yes	☐ No
3. California Children's Services (CCS) Paneled Provider?	☐ Yes	☐ No
4. Accredited? If Accredited, please list Accrediting Agency:	☐ Yes	☐ No
5. Business License (local or County)	☐ Yes	☐ No
6. Professional Liability Insurance (required per Credentialing Policy)	☐ Yes	☐ No
7. DEA Registration	☐ Yes	☐ No
8. CA address listed on DEA registration? If DEA registration is Exempt, please list the fee exempt institution:	☐ Yes	☐ No
9. CHOC Health Alliance Provider in the past?	☐ Yes	☐ No
10. License ***ever*** or currently denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions?	☐ Yes	☐ No
11. Willing to accept Medi-Cal patients and Medi-Cal reimbursement rates?	☐ Yes	☐ No
12. Practice Location(s) and Office Hour(s):		
13. Staff Language(s):		
14. Age Limitation:		
15. Other Health Network/IPA affiliation(s):		
16. Clinical services performed that are not typically associated with specialty:		
17. Electronic Claims Clearing House or direct capabilities:		
18. Electronic Health Record (EHR) System (if applicable):		

By typing your name below, you are signing this form electronically and attesting that all the information provided is true and correct to the best of your knowledge.

TYPE YOUR FULL NAME AND TITLE: Date:

If you do not completely fill out the LOI Questionnaire or submit it without the required document(s), your request will not be considered.
The completion of the LOI Questionnaire does not guarantee acceptance into the CHOC Health Alliance network.