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.

Physician/Practitioner: _____

Primary Specialty: _____ **Subspecialty:** _____

Group Name: _____

Office Address: _____

Office Telephone: _____ **Office Fax:** _____

Office Manager's Name: _____

Office Manager's E-mail: _____

Individual NPI: _____ **Group NPI:** _____

☐ **PCP** ▣ **Specialist** ☐ **Mid-Level** ☐ **Allied Health Prof** ☐ **Urgent Care** ▣ **Facility/Vendor**

1. Pediatric specialty or training?	☐ Yes	☐ No
2. Admitting Privileges: a. Hospital Admitting Privileges at CHOC Hospital? b. Hospital Admitting Privileges at CHOC Children's at Mission Hospital (CHOC Mission)? c. Admitting Privileges at the following hospitals: *If you do not have hospital privileges, please have a written plan for continuity of care.*	☐ Yes ☐ Yes	☐ No ☐ No
3. Actively Enrolled in Medi-Cal Program (California Department of Health Care Services)?	☐ Yes	☐ No
4. California Children's Services (CCS) Paneled Provider?	☐ Yes	☐ No
5. Board Certified? If board eligible, please list date of scheduled exam:	☐ Yes	☐ No
6. CA address listed on DEA registration? If DEA registration is Exempt, please list the fee exempt institution:	☐ Yes	☐ No
7. CHOC Health Alliance Provider in the past?	☐ Yes	☐ No
8. Medical license ***ever*** or currently denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions?	☐ Yes	☐ No
9. Willing to accept Medi-Cal patients and Medi-Cal reimbursement rates?	☐ Yes	☐ No
10. Practice Location(s) and Office Hour(s):		
11. Provider Language(s): English and Spanish		
12. Staff Language(s): English and Spanish		
13. Age Limitation: None		
14. Other Health Network/IPA affiliation(s): None		
15. Clinical services performed that are not typically associated with specialty: N/A		
16. Electronic Claims Clearing House or direct capabilities: Yes		
17. Electronic Health Record (EHR) System (if applicable): N/A		
18. Outpatient Surgery Center affiliation(s): N/A		
19. Ownership in the following Outpatient Surgery Center(s): N/A		
20. Curriculum Vitae (CV) will be: ☐ Attached to the Letter of Interest Questionnaire		

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.