

## Letter of Interest Form

- This form should **ONLY** be used for new providers interested in contracting with Chorus Community Health Plans.
- Please complete this form by answering the following questions. This information will help us determine if your qualifications align with the service needs of our network.
- Important: Please include your W-9 and liability Insurance forms with your submittal of this questionnaire.
- Email completed forms to Provider Contracting at [CCHP-Contracting@chorushealthplans.org](mailto:CCHP-Contracting@chorushealthplans.org).
- If you are adding more than one practitioner to a group, please include a full roster along with your Letter of Interest Form.

If you are the **only practitioner in your group** and bill with your **NPI#** please complete this section.

Primary Practice Location							
Practice/Group Business Name							
Federal Tax ID#				NPI#			
Practitioner Name Last, First, MI							
Primary Practice Address				City	State	Zip	
Phone Number				Fax Number			
Email							
Location Hours (List the hours the practice is open for each day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
List Languages Spoken				List in Provider Directory? Y/N			
Does this site provide American Sign Language? Y/N				Do you provide Telehealth services? Y/N			
Does this site have ADA compliant equipment? Y/N				What type of patients do you treat?		Children <input type="checkbox"/> Adult <input type="checkbox"/> Pregnant Women <input type="checkbox"/>	
Please list the services provided in your office							

If you have **more than one practitioner in your group and bill with a NPI2**, please complete this section and attach a full provider roster.

Primary Practice Location							
Practice/Group Business Name							
Federal Tax ID#				NPI2#			
Practitioner Name Last, First, MI							
Primary Practice Address				City	State	Zip	
Phone Number				Fax Number			
Email							
Location Hours (List the hours the practice is open for each day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
List Languages Spoken				List in Provider Directory? Y/N			
Does this site provide American Sign Language? Y/N				Do you provide Telehealth services? Y/N			
Does this site have ADA compliant equipment? Y/N				What type of patients do you treat?		Children <input type="checkbox"/>	Adult <input type="checkbox"/>
Please list the services provided in your office						Pregnant Women <input type="checkbox"/>	

Additional Practice Location							
Practice/Group Business Name							
Federal Tax ID#				NPI#			
Practitioner Name Last, First, MI							
Primary Practice Address				City	State		Zip
Phone Number				Fax Number			
Email							
Location Hours (List the hours the practice is open for each day)	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
List Languages Spoken				List in Provider Directory? Y/N			
Does this site provide American Sign Language? Y/N				Do you provide Telehealth services? Y/N			
Does this site have ADA compliant equipment? Y/N				What type of patients do you treat?		Children <input type="checkbox"/> Adult <input type="checkbox"/> Pregnant Women <input type="checkbox"/>	
Please list the services provided in your office							

Billing Contact Information							
Primary Contact Person Name							
Federal Tax ID#				NPI#			
Billing Address				City	State		Zip
Phone Number				Fax Number			
Email							

Credentialing Contact Information				
Primary Contact Person Name				
Address		City	State	Zip
Phone Number		Fax Number		
Email				

Contracting Contact Information				
Primary Contact Person Name				
Address		City	State	Zip
Phone Number		Fax Number		
Email				

**Upon Completion of this form:**

- Please review all the answers and information you provided is correct.
- Attach your W-9 form along with this questionnaire and email it to Provider Contracting [CCHP-Contracting@chorushealthplans.org](mailto:CCHP-Contracting@chorushealthplans.org).
- If approved, Chorus Community Health Plans will email you a Provider Network Agreement within 30 days of receiving the letter of interest.
- Please attach a copy of the facility's insurance certificates including insurer affording coverage, policy number, effective date, and expiration date.