Letter of Interest Form

- This form should **ONLY** be used for new providers interested in contracting with Chorus Community Health Plans with our Medicaid BadgerCare Plus or Individual & Family Plans Line of Business.
- 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.
- To enroll a chiropractic provider in our Individual & Family Plans network please contact Wisconsin Health Choice at 262-201-4327.
- If you are adding more than one Practitioner to a group, please include a full roster along with your Letter of Interest Form.

Network Participation Request

☐ Medicaid BadgerCare Plus ☐ Individual and Family Plans ☐ Both Plans

If you are the **only practitioner in your group** and bill with your **NPI1** please complete this section.

Primary Practice Location

Practice/Group Business Name							
Federal Tax ID#			**NPI1#**				
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 ☐ Adult ☐ Pregnant Women ☐		
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 ☐ Adult ☐ Pregnant Women ☐			
Please list the services provided in your office							

CHORUS COMMUNITY HEALTH PLANS

Additional 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 ☐ Adult ☐ Pregnant Women ☐		
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 Relations at CCHP-Contracting@chorushealthplans.org.
- If approved, Children's Community Health Plan 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.