



For internal use only		
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Letter of Interest Questionnaire

This form may supplement, or replace, a letter of interest for our provider network. Please answer the following questions. This information will help us in assessing your qualifications with the service needs of our network. Once completed, please fax to 832-825-8750, Attn: LOI Committee. For questions, call 832-828-1008.

Demographic Information

Name: _____

Is this a group practice? _____ Group name: _____

Service address: _____ Zip code _____

Billing address: _____ Zip code _____

Phone: _____ Fax: _____ Tax ID number: _____

NPI number: _____ (required) TPI number: _____ (required)

Specialty: _____

Provider Service Information

1) What services do you provide?

2) What is unique about the services you provide?

3) Will you accept both STAR and CHIP members/patients? Yes No

4) What are your hours of operation? _____

5) If you are a behavioral health provider do you provide home visits? Yes No

6) If you are a PCP do you provide EPSDT services? Yes No

7) Do you participate in the VFC program? Yes No

8) What other Medicaid and CHIP plans are you enrolled?

9) Which hospitals do you have admitting privileges?

