Provider Add Form

Use this form to add a provider or location to an active CHRISTUS Health Plan agreement. Submit this completed form to the Provider Relations Team at CHP.providernetwork@christushealth.org and allow 30 days for completion.

Name of Contracted Provider as listed on the W-9: _____

DBA Name _____

Group NPI _____ Group Tax ID _____

Address _____City_____State _____ Zip_____

County _____ Phone _____ Fax_____

Email_____

Name of Provider to be added to the above agreement:

Last Name _____ First Name _____ MI ____ Degree _____

Primary Specialty _____ Secondary _____

Primary Care Provider (PCP)? □Yes □No Offer Telehealth? □Yes □No

Provider NPI _____ Taxonomy _____

Medicare # _____ CAQH # _____

Credentialing Contact _____

Credentialing Phone _____

Credentialing Email _____

Address of additional location to add to the above agreement:

Address _____City_____State _____ Zip_____

County _____ Phone _____ Fax_____

PCP's Only:

Covering Physician Name _____ Specialty _____

Address _____City_____State _____ Zip_____

Phone _____ Email_____

***Participation with USFHP requires a completed Background Release Form.