Cigna HealthSpring | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice | TEXAS Health and Human Services

Credentialing Form/Provider Directory Information

Provider Name: _____

Service Location Address: _____

Office Hours: Please provide your hours in the following format: **8am – 430pm**. If you do not have hours on a specific day, please mark N/A

Sun. _____ Mon. _____ Tues. _____ Weds. _____

Thurs. _____ Fri. _____ Sat. _____

Phone Number: _____ Fax Number: _____ Email: _____

Languages Spoken in Office: _____

NPI Number: _____ Tax ID Number: _____

Multiple Locations? ☐ Yes ☐ No ***If yes, please complete an additional form per location***

Panel Status: ☐ Accepting New Members ☐ Accepting Existing Members Only ☐Closed Panel ☐N/A (not a PCP)

Do you provide in home care for patients? ☐Yes ☐No

*If yes, please specify what location: ☐ Patient Home ☐ Nursing Home ☐ Other

Do you provide in home care for patients? ☐Yes ☐No

Are you ADA compliant? ☐Yes ☐No

Office Site Accessibility Form

1.	Is your current practice location clearly marked and visible from the street?	☐Yes	☐No
2.	Is your current practice location easily accessible via public transportation?	☐Yes	☐No
3.	Is your office accessible to people with disabilities:	☐Yes	☐No
	a. Designated parking for disabled?	☐Yes	☐No
	b. Wheelchair ramps?	☐Yes	☐No
	c. Exam rooms with accessible equipment(s)?	☐Yes	☐No
	d. Restroom accessible for people with disabilities (including handrails)?	☐Yes	☐No
	e. Auto open external doors?	☐Yes	☐No
4.	Do you have procedures in place for handling visually and/or hearing disabled patients?	☐Yes	☐No
	a. ASL interpretation available?	☐Yes	☐No
	b. ADA compliance on service animals?	☐Yes	☐No
	c. Materials in Braille and large print?	☐Yes	☐No
5.	Does your waiting room accommodate patients in wheelchairs or motorized scooters?	☐Yes	☐No
6.	If you offer radiology and/or other diagnostic services; are they accessible to disabled patients?	☐Yes	☐No
7.	Is your office a NCQA certified patient center medical home?	☐Yes	☐No
	a. If yes, what level (please circle) 1 2 3 4 5		

8. Special skills, experience, and training? (Please check all that apply)

☐Physical Disabilities ☐Chronic Illness ☐Serious Mental Illness

☐Deafness or Hard-of-Hearing ☐HIV/AIDS ☐Blindness or Visual Impairment

☐Other areas of Specialty. For Behavioral Health providers this includes training and experience treating: ☐Child Welfare ☐Trauma ☐Substance Abuse

Signature _____ Title _____ Date _____