4055 International Plaza Ste 605
Fort Worth, TX 76109
P: (817) 484-6274
F: (817) 420-9661

TIOPA BASIC INFORMATION PROFILE

Personal Information

_____ _____ _____ □ Male
Last Name, First Name Middle Initial, Prof Suffix | Date of Birth | Ethnicity | □ Female

_____ _____ _____ _____
CAQH # | NPI | SSN | Maiden/Other Names Used

Accept texts?
_____ _____ _____ □ Yes □ No
Personal Email Address | Work Email Address | Cell Phone

US Citizen:
□ Yes □ No (Country)_____

Visa Information:
_____ _____ □ Resident
Number | Exp Date □ Work
□ Student

Directory Information

Are you accepting new patients? □ Yes □ No
Are you a PCP? □ Yes □ No ***(Note: PCPs require site visit every 5 years)
Are you a specialist? □ Yes □ No
Are you a hospitalist? □ Yes □ No
Are you a behavioral health provider? □ Yes □ No

Gender Limits:
□ Both
_____ _____ □ Female Only
Provider Language(s) | Ages Seen □ Male Only

_____ _____ Board Certified? □ Yes □ No
Primary Specialty | Primary Taxonomy

_____ _____ Board Certified? □ Yes ☑ No
Secondary Specialty | Secondary Taxonomy

_____ _____ Board Certified? □ Yes □ No Other
Specialty | Other Taxonomy

_____ □ Applied (Pending)| □ Active | □ Courtesy | □ Other_____
Primary Hospital (Specify)

_____ □ Applied (Pending)| □ Active | □ Courtesy | □ Other_____
Secondary Hospital (Specify)

FOR NPs & PAs ONLY

_____ _____ _____
Supervising Physician (Last, First Cred) | Supervising's Specialty | Supervising's NPI

_____ _____ NP/PA's information listed on Supervising TMB?
Supervising TX Lic. # | Supervising DEA □ Yes □ No

AF-10.3.2022

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PRACTICES WITH 3+ ADDRESSES NEED TO SUBMIT A Tiopa Roster TO ENSURE ACCURACY

PRACTICE LOCATION ADDENDUM

Legal Business Name *as listed on Line 1 of W9 _____ Tax ID (TIN) _____ Type 2 NPI _____

DBA/Practice Name *as it appears in directories _____ Office Web Address _____ Use remittance as correspondence? □ Yes □ No

Remittance Address *where you wish to receive payment (on W9) _____ Ste _____ Remit City _____ State _____ Zip+4 _____ Billing Contact/Email _____

Primary Practice Location (No residential addresses)

Street Address _____ Ste _____ City _____ State _____ Zip+4 _____

Office Phone # _____ Office Fax # _____ County _____ Office Email _____

Medicare PTAN _____ Office Contact Name _____ Use as correspondence address □ Yes □ No

Office Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

List in directory? □ Yes □ No
Type of required 24/7 phone coverage?
□ Answering Service Phone #_____
□ Voicemail with instructions

Do you offer telemedicine? □ Yes □ No
Meets ADA Accessibility? □ Yes □ No
Handicapped Accessible:
□ Building □ Parking □ Restroom

Additional Practice Location (No residential addresses)

Street Address _____ Ste _____ City _____ State _____ Zip+4 _____

Office Phone # _____ Office Fax # _____ County _____ Office Email _____

Medicare PTAN _____ Office Contact Name _____ Use as correspondence address □ Yes □ No

Office Hours: Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____

List in directory? □ Yes □ No
Type of required 24/7 phone coverage?
□ Answering Service Phone #_____
□ Voicemail with instructions

Do you offer telemedicine? □ Yes □ No
Meets ADA Accessibility? □ Yes □ No
Handicapped Accessible:
□ Building □ Parking □ Restroom

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PRACTICES WITH 3+ ADDRESSES NEED TO SUBMIT A Tiopa Roster TO ENSURE ACCURACY

Only complete if applicable

Correspondence Address

_____ _____ _____ _____ _____
Street Address Ste City State Zip+4

_____ _____ _____ _____
Phone # Fax # County Email

_____ Send TIOPA invoices here?
Contact Name □ Yes □ No

Billing or Credentialing Agency Information

_____ _____ _____ _____ _____
Street Address Ste City State Zip+4

_____ _____ _____ _____
Phone # Fax # County Email

_____ Send TIOPA invoices here? Can access provider WebView?
Contact Name □ Yes □ No □ Yes □ No

Billing agency? □ Yes □ No
Credentialing company? □ Yes □ No

CLIA/X-Ray Information

Do you offer lab services on site? □ Yes □ No
Do you offer x-ray services on site? □ Yes □ No

List CLIA Certificates: List x-ray certificates:

_____ _____
_____ _____
_____ _____

Tiopa Built by Physicians for Physicians

PROVIDER NAME: _____ NPI: _____

SPECIALTY: _____

COVERING PROVIDER(S) IN CASE OF AN EMERGENCY OR ON VACATION

COVERING PHYSICIAN: _____

COVERING PHYSICIAN: _____

COVERING PHYSICIAN: _____

COVERING PHYSICIAN: _____

(Cannot be a hospitalists group or ER)

NON-ADMITTING PHYSICIAN FORMALIZED INPATIENT COVERAGE

In lieu of your admitting inpatients. NCQA requires documentation indicating how your patients will be admitted.

If you have hospital admitting privileges, please leave blank.

ADMITTING PHYSICIAN: _____

ADMITTING PHYSICIAN: _____

ADMITTING PHYSICIAN: _____

SIGNATURE: _____ DATE: _____

(Must be signed by physician- No signature stamps accepted)

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DEA PRESCRIBING PROVIDER FORM

PROVIDER NAME: _____ NPI: _____

SPECIALTY: _____

Select the most appropriate:

☐ I have a current Texas DEA

☐ I have applied for a Texas DEA, but I have not received certificate

☐ I have an out of state DEA and plan to apply for a Texas DEA

I acknowledge that I will forward my valid Texas DEA, and until received I understand that I cannot write prescriptions for controlled substances without the Texas DEA.

Physician Signature: _____ Date: _____

Must be signed by physician – no signature stamps

PRESCRIBING PLAN FOR CONTROLLED SUBSTANCES

If the provider above does not have a valid Texas DEA when starting a practice, they must have an interim physician who will prescribe as needed. A hospitalist group or ER physician **will not** be accepted. Please list below:

INTERIM PRESCRIBING PHYSICIAN: _____

DEA NUMBER: _____ EXPIRATION DATE: _____

INTERIM PRESCRIBING PHYSICIAN: _____

DEA NUMBER: _____ EXPIRATION DATE: _____

Tiopa Built by Physicians for Physicians

FINANCIAL INTEREST DISCLOSURE

Financial Disclosure's purpose is intended to reduce the likelihood of health care practitioners making unnecessary referrals to other health care providers in which health care practitioners have a financial interest. Any health care practitioner who wishes to participate in the Texas workers' compensation system in any capacity is required to disclose to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) the identity of any health care provider in which the health care practitioner has a financial interest in: a hospital, emergency clinic, outpatient clinic, imaging center, has an immediate family member who has a financial interest, or a health care provider that employs another health care provider who has a financial interest. Health Care providers can submit financial disclosure information online to the TDI-DWC via the TXCOMP Provider System at: https://appscenter.tdi.texas.gov/TXCOMPWeb/common/home.jsp

More information regarding financial disclosure: http://www.tdi.state.tx.us/pubs/fastfacts/fffinancialdisc.pdf

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Do you have financial interests in any health care providers? □ Yes □ No

If yes, complete:

Name: _____

Provider/Practice/Facility Name: _____

Tax ID Number(s): _____

Nature of Financial Interest: _____

Signature: _____ Date: _____

TIOPA WORKERS' COMPENSATION SERVICES INFORMATION

Will you be accepting workers' compensation patients?

☐ **Yes** ☐ **No**

If "Yes" please complete sections A, B & C.
If "No" please complete section A only.

A. General Information

Provider Name: _____ NPI: _____

Legal Business Name: _____ Tax ID: _____

B. Accepting Worker's Compensation:

If you will be participating with Workers' Compensation networks, please complete the following:

Will you accept NEW Workers' Compensation patients? ☐ Yes ☐ No
Will you act as a Primary Treating Physician (PTP)? ☐ Yes ☐ No

Your practice for Workers' Compensation can best be described as
(Initial one statement that best applies):

_____Initial injury care for workers

_____Initial visit for area of specialty care only. Specialty: _____

_____Specialty and/or referral care only. Specialty: _____

Are you fully authorized and certified by the Division of Workers' Compensation (DWC) to certify Maximum Medical Improvement (MMI) and assign an impairment rating on an injured workers' claim?
☐ Yes ☐ No

Enclose documentation supporting your Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and your current status on the Approved Doctors List (ADL).

C. Backup Coverage:

Texas Insurance Code states that Networks must have availability and accessibility 24 hours per day, seven days per week. If you are not available, who will serve as your backup provider?

_____ _____
Covering Provider Name Covering Provider Phone

_____ _____
Signature Printed Name

_____
Date