

Community Health Network Physician Referral Questionnaire

If you do *not* wish to participate in the physician referral program please see the instructions at the bottom of the last page.

General Physician Information:

Name: _____
First
MI
Last
(Jr./Sr.)

Title: MD DO DDS Ph.D. Other: _____

Gender: Male Female Birth Date: ____/____/____

In what year did you begin practicing? _____ Since what year have you resided in this area? _____

Situations where you would NOT like to receive a referral _____

Personal information that you would like referral candidates to know about you, not provided for elsewhere in this questionnaire

Formal Education:

Institution Name

Year Grad.

Medical degree		
Internship(s):		
Residency(ies):		
Fellowship(s):		

Areas of Interest

Credentials/additional training/education that you would like referral candidates to know about (other than medical degree, internship, residency, and fellowship programs). _____

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Specialty(ies):	Primary Specialty? Y/N	Board Certified? Y/N	Accept referrals for this specialty? Y/N

Office Information: (The following information is needed for each additional office. You may copy this sheet.)

Group Practice Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____ Zip: _____

Closest cross streets: _____

Is this your Primary office location (Y/N)? _____

Voice Phone Number: (_____) _____ - _____ Fax Phone Number: (_____) _____ - _____

Physician's e-mail address: _____

Physician's Website: _____

What days/hours will someone be at this office to assist with scheduling?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	_____	_____	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____	_____	_____

Please indicate with a (Y/N) whether or not you generally see patients during the time frames indicated below.

Note: Specific appointment time availability will be determined at the time the referral is made.

Weekdays: [____] Evenings: [____] Saturdays: [____] Sundays: [____]

What is the average waiting period (in days) for scheduling an acute care appointment? _____

Will you see a patient (non-acute) within 48 hours? (Y/N) _____

Does this location have: Public transportation (Y/N) ? _____ Handicap access (Y/N) ? _____

What is the average new patient fee for a patient's first visit to this location? _____

What foreign languages, if any, are spoken at this location?

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Affiliations: Please mark below (with a 'X') the facilities that you currently have credentials for:

- | | |
|---|--|
| <input type="checkbox"/> CHA – Community Hospital Anderson | <input type="checkbox"/> CHE – Community Hospital East |
| <input type="checkbox"/> CHN – Community Hospital North | <input type="checkbox"/> CHS – Community Hospital South |
| <input type="checkbox"/> TIHH – The Indiana Heart Hospital | <input type="checkbox"/> CPI – Community Physicians of Indiana |
| <input type="checkbox"/> Indiana Surgery Center | <input type="checkbox"/> Get Acquainted Visits |
| | <input type="checkbox"/> Same Day Appointments |
| <input type="checkbox"/> Indiana Surgery Center Noblesville | <input type="checkbox"/> Indiana Surgery Center South |
| <input type="checkbox"/> Indiana Surgery Center East | <input type="checkbox"/> Indiana Surgery Center Kokomo |
| <input type="checkbox"/> Indiana Surgery Center North | |

Insurance Participation Please check the insurances below that are accepted at your office(s)

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Commercial / Indemnity | <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicare Assignment |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Champus |
-
- | | |
|--|---|
| <input type="checkbox"/> CHA HEALTHNET (TRICARE)
<input type="checkbox"/> CHA MILITARY
<input type="checkbox"/> EPO ENCIRCLE
<input type="checkbox"/> EPO UNITED HEALTHCARE
<input type="checkbox"/> HMO ADVANTAGE HEALTH SOLUTIONS
<input type="checkbox"/> HMO AMERICAS HEALTH PLAN
<input type="checkbox"/> HMO ANTHEM
<input type="checkbox"/> HMO CIGNA
<input type="checkbox"/> HMO FEDERATED
<input type="checkbox"/> HMO HEALTHMARK - CHN EMPLOYEES
<input type="checkbox"/> HMO HOWARD COMM RISK REFERRAL NETWORK
<input type="checkbox"/> HMO SUBURBAN HEALTH ORGANIZATION (SHO)
<input type="checkbox"/> HMO UNITED HEALTHCARE
<input type="checkbox"/> IND ANTHEM
<input type="checkbox"/> IND COFINITY
<input type="checkbox"/> IND FORTIS/TIME
<input type="checkbox"/> IND MASS MUTUAL
<input type="checkbox"/> IND MUTUAL OF OMAHA
<input type="checkbox"/> IND NATIONAL PPO NETWORK
<input type="checkbox"/> IND NATIONWIDE
<input type="checkbox"/> MCA ADVANTAGE PREFERRED NETWORK
<input type="checkbox"/> MCA ANTHEM MEDICARE PREFERRED
<input type="checkbox"/> MCA HUMANA MEDICARE HMO
<input type="checkbox"/> MCA PPO ADVANTAGE PREFERRED PLUS
<input type="checkbox"/> MCA PPO CHOICECARE MEDICARE ADVANTAGE
<input type="checkbox"/> MCA SECURE HORIZONS/EVERCARE
<input type="checkbox"/> MCA TODAY'S OPTIONS PPO
<input type="checkbox"/> MCA WELLCARE
<input type="checkbox"/> MCD ADVANTAGE CARE SELECT
<input type="checkbox"/> MCD ANTHEM HIP (HEALTHY INDIANA PRGM)
<input type="checkbox"/> MCD MANAGED HEALTH SERVICES (MHS)
<input type="checkbox"/> MCD MDWISE CARE SELECT
<input type="checkbox"/> MCD MDWISE PROHEALTH (HOOSIER HLTHWISE)
<input type="checkbox"/> POS ADVANTAGE
<input type="checkbox"/> POS AETNA
<input type="checkbox"/> POS CIGNA (FLEX) | <input type="checkbox"/> POS SAGAMORE AMBASSADOR CARE
<input type="checkbox"/> POS UNITED HEALTHCARE
<input type="checkbox"/> PPO 1HN/GREAT WEST
<input type="checkbox"/> PPO AETNA
<input type="checkbox"/> PPO ANTHEM HEALTH PLAN
<input type="checkbox"/> PPO ANTHEM MEDICARE PREFERRED
<input type="checkbox"/> PPO BANKERS LIFE
<input type="checkbox"/> PPO BEECH STREET
<input type="checkbox"/> PPO CIGNA
<input type="checkbox"/> PPO COMMUNITY HEALTH ALLIANCE
<input type="checkbox"/> PPO EMPLOYERS HEALTH
<input type="checkbox"/> PPO ENCORE
<input type="checkbox"/> PPO FEDERATED
<input type="checkbox"/> PPO FIRST HEALTH/CCN
<input type="checkbox"/> PPO FORMOST
<input type="checkbox"/> PPO FORTIFIED PROVIDER NETWORK
<input type="checkbox"/> PPO GALAXY HEALTH NETWORK (GHN)
<input type="checkbox"/> PPO HEALTH CHOICE - CHN EMPLOYEES
<input type="checkbox"/> PPO HUMANA CHOICE CARE
<input type="checkbox"/> PPO LUTHERAN PREFERRED
<input type="checkbox"/> PPO MULTI PLAN
<input type="checkbox"/> PPO NPPN/PLAN CARE AMERICA
<input type="checkbox"/> PPO PPO NEXT
<input type="checkbox"/> PPO PRINCIPAL
<input type="checkbox"/> PPO PRIVATE HEALTH CARE SYSTEM
<input type="checkbox"/> PPO PRUDENTIAL
<input type="checkbox"/> PPO SAGAMORE PLUS NETWORK
<input type="checkbox"/> PPO SAGAMORE SELECT
<input type="checkbox"/> PPO SOUTHEASTERN INDIANA HEALTH ORGANIZ
<input type="checkbox"/> PPO UNITED HEALTHCARE
<input type="checkbox"/> PPO USA/MCO
<input type="checkbox"/> WC CORVEL
<input type="checkbox"/> WC FIRST HEALTH/CCN
<input type="checkbox"/> WC PPO NEXT
<input type="checkbox"/> WC USA/MCO |
|--|---|

Payments Types MC VisaDiscover Am Ex Cash Check

Community Health Network

Physician Detail Report

The Community Physician Referral Service may be accessed via the telephone or the Internet. Prospective patients may speak with a call advisor or visit eCommunity.com to search for a physician, locate a physician's address or telephone number, or identify a physician who meets specific criteria that is important to the consumer (i.e. education, location, gender). You may elect to take part in the program in one of several ways. **Please check below how you wish to be included:**

Check	Definition
	<p>Listed and accepting referrals (new patients)</p> <ul style="list-style-type: none">• Your information will be available through the call advisors and on eCommunity.com.• You are currently accepting new patients and would like your name provided to prospective patients.
	<p>Listed and NOT accepting referrals (new patients)</p> <ul style="list-style-type: none">• Your name, practice, address, and telephone will be available if someone speaks with a call advisor and asks specifically for your address or telephone number.• Your name, practice, address, and telephone will be available through eCommunity.com for information only; you will be listed as not accepting new patients at this time.
	<p>You do not wish to participate in the Community Health Network Physician Referral Service and would like to have your listing deleted.</p>

Physician Signature _____ Date _____

Please return this form to:

Debbie Kenemer
Community Health Network
Interactive Marketing Manager
7330 Shadeland Station, Ste 100
Indianapolis, IN 46256

Or via fax at 317.621.3627