

Strategy 1A: Medicaid Hospital Data Maintenance

Onboarding Form for Existing Local HIE Connection

LOCAL HIE ORGANIZATION INFORMATION:

Name of Organization:	Date Form Submitted:
Point of Contact Name: (Last, First)	Phone Number:
Point of Contact Title:	Email Address:

CONNECTIVITY TYPE: *Hospital ADT*

% Medicaid ____ # of beds ____

Requires 10+% Medicaid patient volume. Hospitals with high bed counts may be approved with lower patient volumes, at the sole discretion of HHSC.

MEDICAID PRACTICE INFORMATION: *Answer ALL questions and if not applicable, insert N/A.*

Practice Name:	
Main Physical Address: (Street, Suite No., City, State, Zip Code)	
Mailing Address: (Street, Suite No., City, State, Zip Code)	
Additional Address(s): (Street, Suite No., City, State, Zip Code) <i>List all provider locations</i>	
Practice Point of Contact Name: (Last, First)	Practice Point of Contact Title:
Practice National Provider Identifier (NPI):	Practice Texas Provider Identifier (TPI):
Practice Website Address:	
Name of EHR Vendor, Product/Version, CEHRT Level:	

ATTACHMENTS:

- Letter of attestation providing Medicaid patient volume of hospital.

OR

- Screenshot showing Medicaid participation and patient volume: Use the HHS Provider Finance Department's Disproportionate Share Hospitals Qualification File for the latest year available, found [here](#).