



## Required Information for Enrollment as an Affiliated Provider of a CSHCN Services Program Enrolled Comprehensive Cleft/Craniofacial Team

Affiliated teams/team members consist of providers or teams of providers that are not based in the same community with the members of the comprehensive team. Affiliated providers facilitate statewide coverage and must be linked with approved comprehensive teams. Affiliated providers must meet the CSHCN Services Program provider enrollment requirements.

I am a provider affiliated with the following cleft/craniofacial team:

Name of cleft/craniofacial (C/C) team: \_\_\_\_\_

Location of C/C team: \_\_\_\_\_  
Physical Address
City
State
Zip

Hospital(s) where C/C team performs services: \_\_\_\_\_

I consult and coordinate the development of a treatment plan with the above comprehensive C/C team according to each individual client's needs.

**A letter of agreement between the affiliated provider and the C/C team, which verifies the linkage and specifies the method of communication and consultation, must accompany this application.**

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**Cleft/Craniofacial Provider** **Date** **CSHCN Services Program TPI**

Please list the information for your cleft/craniofacial team administrator below.				
Name	Physical Address	Accounting/Billing Address	Telephone Number	Email Address