

REQUEST FOR INCREASE IN 1500 CAPACITY

Please list the names, mid-level practitioners (physician extenders), position, Medicaid provider numbers (if required), Texas professional licensure and general responsibilities of each of your staff who provide billable services to STAR patients. Attach additional sheets if necessary.

Please describe patient care hours of all office locations serving STAR patients. Attach additional sheets if necessary.

Please describe after hour coverage (24 hours a day/7 days a week) phone numbers available to STAR patients for your practice.

I verify that I have personally reviewed the information provided to the department on this form and that it accurately reflects my staff and office locations. I understand that the representations made by me on this form will be relied upon by the department in granting me an exception to the existing STAR patient enrollment limitations. Any false or misleading statement made by me to gain a benefit to which I am not otherwise entitled can be considered a false claim as that term is defined by state and federal law, and I may be subject to severe sanctions and penalties under those laws. I also affirm my above responsibilities pursuant by the following signature.

Printed name and Medicaid provider number:

Signature of Provider

Date