California Direct Contract

Add To Group Request Form for Existing Contract.

Application Instruction to Physicians/Licensed Health Care Professionals:

- Please note that completion of this Add to Group Request Form and/or credentialing application does not guarantee acceptance in the Health Net provider network.
- Health Net will review your request to ensure you meet initial participation criteria, including maintaining admitting privileges at a Health Net network hospital.
- Please type or print legibly. Incomplete forms will not be considered.
- Application processing and provider credentialing may take 90 to 120 days after a completed Add to Group Form and all required information has been received.
- Health Net participates with the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource, which can simplify your application process. If you participate with CAQH, please indicate your ID # below. If you do not participate, a Health Net representative will assist you during the contracting process. For more information, and a demonstration, visit www.caqh.org.

Physician /Practitioner Information (* Required Fields)

In order to streamline your request, please complete required fields. Your form may be returned if it is incomplete.

***First Name:**		MI:	*Last Name:	Suffix:	*Degree/Certification:
*Date of Birth	*Gender:	Language:	*NPI#:	*Medical School (MD):	*Graduate Year:
***Practice Address:** *STREET:					
*CITY:		*STATE:		*ZIP CODE:	
*Practice Telephone #:		Practice Fax #:	Office Hours:		
CA DEA # (if Applicable)		Exp Date:	CAQH ID (if Applicable):	Tele Health	
Additional Practice Location (Yes/No) ☐ If yes, please attach document(s) with practice address		Display in the Directory (default is yes): ☑ Yes ☐ No		Status (default is accepting): ☑ Accepting New Patients ☐ Prior Patients Only	
Mailing Address (if different than practice address): STREET:					
CITY:		STATE:		ZIP CODE:	
Remittance Address (if different than practice address): STREET:					
CITY:		STATE:		ZIP CODE:	
*Group Name Tax Title		*Group NPI#:	*TAX ID:		
*Applying As: *Check All that applies.* (*Minimum of one box check) ☐ PCP ☐ Specialist ☐ Hosp Based		☐ Behavioral Health		ABA ☐ Yes ☐ No	
*Primary Specialty:		Board Cert Date (if applicable):	*CA License #:	License Type:	
Secondary Specialty:		Board Cert Date (if applicable):	CA License #:	License Type:	
Adding Extenders Only: Please Provide Supervising Provider Name and License Supervising Provider Name:			Supervising Provider License #:		
Please list your Hospital Affiliations (or Covering Physicians) if applicable:				Hospital Privileges:	
Person to contact regarding this request:		Contact Phone #:	Contact Email:		
Medi-Cal Requirements: ***(if applicable)*** Med-Cal ID:		Limit by Age:		Limit by Gender:	

PLEASE RETURN THIS FORM, W-9, Medi-Cal Training Attestation (if applicable) to **DNPNM_DVP@HealthNet.com**

For Behavioral Health Only: Please check any of the following focus that apply to your practice. You may select up to 20.

	ADDICTIONOLOGIST - ASAM CERTIFIED
	ADHD
	ADOLESCENTS
	ADULTS
	ANGER MANAGEMENT
	ANXIETY
	BIPOLAR DISORDER
	CBT FOR INSOMNIA
	CHILD ABUSE
	CHILDREN(6-12)
	CHRISTIAN COUNSELING
	CHRONIC/TERMINAL ILLNESS
	COMPULSIVE GAMBLING
	COUPLES/MARRIAGE THERAPY
	DEPRESSION
	DEVELOPMENTALLY DISABLED
	DIALECTICAL BEHAVIORAL THERAPY
	DISSOCIATIVE DISORDERS
	DYADIC CARE
	EATING DISORDERS
	ECT
	EMDR
	ETHNIC/CULTURAL ISSUES
	FACITIOUS DISORDERS
	FAMILY THERAPY
	FAMILY VIOLENCE
	GENDER DYSPHORIA
	GERIATRIC THERAPY
	GRIEF/BEREAVEMENT
	HIV
	IMPULSE CONTROL AND CONDUCT DISORDERS
	INFERTILITY
	LEARNING DISABILITIES
	LGBTQ
	NALTREXONE/VIVITROL
	NEUROPSYCHIATRIC TESTING
	OCD
	PAIN MANAGEMENT
	PANIC/PHOBIA
	PERSONALITY DISORDERS
	PRESCHOOL(UNDER 6)
	PSYCHOLOGICAL TESTING
	PSYCHOTIC/SCHIZOPHRENIA
	PTSD
	SEX OFFENDER TREATMENT
	SEXUAL DYSFUNCTION
	SEXUAL/PHYSICAL ABUSE
	SLEEP DISORDERS
	SOMATIC SYMPTOMS AND RELATED DISORDERS
	STRESS
	SUBOXONE/BUPRENORPHINE TREATMENT
	SUBSTANCE USE DISORDERS
	TRANSCRANIAL MAGNETIC STIMULATION