California Physician Network Participation Request Form

Application Instructions to Physicians / Licensed Health Care Professionals:

- *Please note that completion of the nomination form and/or credentialing application does not guarantee acceptance in the Health Net provider network.*
- Your nomination will be reviewed and a response will normally be mailed within two weeks.
- 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 Participating Provider Agreement has been signed 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.

Adding a Provider to an Existing Health Net Contract:
If you are requesting to add one or more practitioners to an existing Health Net contract with your group use the following link: Add a Physician to an Existing Contract here. This form is to request new agreements ONLY.

☐ We are a practice group that is currently contracted with Health Net, and are seeking to add the following provider to our existing group agreement.

PHYSICIAN / PROVIDER INFORMATION

Medical Group Name:				
First Name:	MI:	Last Name:	Suffix:	Degree:
Practice Address: STREET:			SUITE:	
CITY:		STATE:	ZIP CODE:	
Telephone #:	Telehealth	Fax #:		
NPI #:	Date of Birth:	Applying As: ◉ PCP ○ Specialist ○ Both		
Medical Specialties:		License #:		
○ I am a solo practitioner billing under an individual Tax ID Number. ○ We are a group practice with multiple providers billing under a single Tax ID number. (Please attach a roster.)				
Tax ID #:				
CAQH Provider ID: IF APPLICABLE - SEE INSTRUCTIONS ABOVE		Age Range Minimum	Age Range Maximum	
Please list your Hospital Affiliations (or Covering Physicians):				
Person to contact regarding this request:				
Contact Phone #:	Contact Email:			

PLEASE RETURN THIS FORM AND A W-9 TO: DNMCU@healthnet.com

Attach File