



Health Net

NETWORK PARTICIPATION REQUEST FORM

Health Net Health Plan of Oregon contracts directly with physicians/providers/facilities in Oregon and southwest Washington

Instructions to Physician/Provider:

- This form allows individual physicians or licensed healthcare professionals to request participation in the Health Net 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.
- **A response to your request will generally be mailed within 30 business days of receipt of this form**
- Please note that completion of the network participation form, credentialing application or CAQH application does not guarantee acceptance in the Health Net Health Plan of Oregon provider network.
- Application processing and provider credentialing may take 90 to 120 days after receipt of all required information.

PHYSICIAN/PROVIDER INFORMATION

First Name:	MI:	Last Name:	Suffix:	Degree (MD,DO,etc.)
Primary Street Address:				Suite:
City:	State:	County:	Zip:	
Telephone No.:	Fax No.:	Email:		
Date of Birth:	Gender:	State License No.:	DEA Certificate No.:	
Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No			CAQH Provider ID (if known):	
Medical Specialty:	Applying as: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health Professional			
<input type="checkbox"/> I am a solo practitioner billing under an individual tax ID number				
<input type="checkbox"/> We are a group practice with multiple providers billing under a single tax ID number (If yes, please provide the medical group name below and attach a physician listing.)				
Tax Identification # (Attach copy of W-9):		NPI#		
Medical Group Name:				
Please List Your Hospital Affiliations:				
Please List Covering Physicians:				

Correspondence/Credentialing Address

Person to contact:	Phone:	Email		
Address:				Suite:
City:	State:	County:	Zip:	

PLEASE RETURN THIS FORM AND A W-9 TO:

Health Net Health Plan of Oregon.
Provider Network Management
13221 SW 68th Parkway
Tigard, OR 97223-8328

Fax: (855) 536-4449