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

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 ☐In Person ☐ Both	
Additional Practice Location (Yes/No) *If yes, please attach document(s)	Display in the Directory: ☐Yes ☐No		Status: ☐Accepting New Patients ☐Prior Patients Only	
Mailing Address: STREET:				
CITY:		STATE:		ZIP CODE:
Remittance Address: STREET:				
CITY:		STATE:		ZIP CODE:
Group Name Tax Title)		Group NPI#:	TAX ID:	
Applying As: *Check All that applies.* ☐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: 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**

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