ANCILLARY
PROVIDER NETWORK
PARTICIPATION REQUEST FORM

Instructions to Ancillary Provider:

- This form allows ancillary providers to request participation in the Health Net of California network.
- Please type or print legibly. Incomplete forms will not be considered.
- Health Net will review request to ensure requirements for participation are met, as well as filling network needs for specialty. Health Net will respond to the request within 30 working days from date of receipt of this form.
- Please note that acceptance of a provider's request form does not guarantee acceptance into the Health Net Ancillary Provider Network.

PROVIDER INFORMATION			
PROVIDER NAME:			
ADDRESS: STREET:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:	**FAX #:**		
NPI #:			
EMAIL ADDRESS:			
ANCILLARY SPECIALTY(S)[1]:			
TAX ID #(s):	**CONTRACTING CONTACT:**		
MEDICARE CERTIFIED: ____Yes ____No			
MEDI-CAL PARTICIPANT: ___Yes ____No			
MULTIPLE LOCATIONS: ___Yes ___No	**SERVICE AREA:**		
ADDITIONAL INFORMATION:			

COVERED ANCILLARY SPECIALTIES

Ambulance/Transportation
Ambulatory Surgery Center (ASC)
Birthing Centers
Community Based Adult Services (CBAS)
Dialysis Facilities
Doula Services
Durable Medical Equipment (DME)
Family Planning Clinics
Hearing Aid Providers
Home Health
Home Infusion
Hospice
Intermediate Care Facility (ICF)
Laboratory
Long Term Acute Care (LTAC)
Orthotics/Prosthetics (O&P)
Ostomy & Medical Supplies
Radiology/MRI/PET
Skilled Nursing Facilities (SNF)
Sleep Study Centers

RETURN THIS FORM WITH A W-9 TO:

Email: PNM_ANCILLARY_Updates@healthnet.com