Health Net®
COMMUNITY SOLUTIONS

CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it within 48 hours via email to HN_Provider_Relations@healthnet.com or send via fax to 1-855-863-5987.

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received the New Provider Training materials from Health Net Community Solutions, Inc. (Health Net), reviewed them for training purposes, and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed Health Net's new provider training online and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to Health Net's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and Health Net. I understand how to access and find information on Health Net's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals located under *Working with Health Net > Contractual > Provider Library.*

_____ _____ _____
Provider name (PRINT) Provider signature Date

_____
Provider address (street, city, ZIP)

_____ _____ _____
Phone number Email address Tax identification number (TIN)

INTERNAL USE ONLY

_____ _____ _____
Received date Data entry date Provider representative

18-790