KERN HEALTH SYSTEMS

Request To Join The Network

Thank you for your interest in joining Kern Health Systems (KHS) network. Please complete this form to have your inquiry properly reviewed.

Facility/Provider Name:

Practice Address:

City: State: Zip:

Telephone #: Fax #:

Second Practice Address:

City: State: Zip:

Email Address:

Specialty or Service Type:

What cities in Kern County do you provide services:

Tax ID:
(Please attach a copy of the W-9)

National Provider Identifier (NPI):

Medi-Cal Enrolled: ◉ Yes ○ No
(If yes please submit a copy of approval letter)

Is this clinic a federally designated Rural Health Clinic: ◉ Yes ○ No
(If yes, please provide any legal, financial, or tax document identifying the facility as a RHC)

Do you have any lab services that require a CLIA waiver or registration: ◉ Yes ○ No
If yes, have you applied for a CLIA number: ◉ Yes ○ No

Are you an Ambulatory Surgery Center: ◉ Yes ○ No
(If yes please submit a copy of your facilities accreditation)

Provider Relations Contracting will reach out to confirm your request was received. Please feel free to attach additional information such as a Program outline or brochure that may help us understand the specialty or services you offer. Please note if your request is approved a contract along with a credentialing packet will be provided. A contract will be contingent on successfully completing the credentialing process. A contract's effective date will be designated after receiving approval of your completion of the credentialing process.

Please email this form along with requested documents to PRcontracting@khs-net.com .