KERN HEALTH SYSTEMS

Network Application Request Form

Thank you for your interest in applying to the Kern Health Systems Provider Network. Please complete the information below and provide the required documents and additional KHS Forms to begin the credentialing process.

CAQH Provider: please indicate your CAQH Number below and return the required documents and KHS Forms. CAQH is the preferred application; however, the CPPA application is acceptable; however, it MUST be the newest version of the California Application and completed in its entirety and returned with the required additional documents and KHS Forms.

Requirements:

- **Must have a valid, current and unrestricted license to practice in State of California;**
- **Possess a valid and current Drug Enforcement Agency (DEA) Certificate or waiver if applicable to practitioners professional specialty;**
- **Maintain professional liability insurance coverage in the amounts of $1million per occurrence/$3 million aggregate (or more) with coverage in the State of California;**
- **Maintain hospital privileges at a participating hospital or have admitting arrangements with a named Hospitalist Group and/or Physician who will admit on your behalf.**
- **Must be enrolled in the Department of Health Care Services Medi-Cal Fee-For-Service Program including enrollment as Order, Referring or Prescribing Provider.**
  ***This is a mandatory State regulation for participation with a Medi-Cal Health Plan.**
- **Must not be currently excluded, suspended, sanction or debarred from (or opted out), or otherwise ineligible to participate in, any health care programs funded in whole or in part by the United States Government, including the Medicare and Medi-Cal Programs.**
- **Additional requirements will be applied as outlined in the KHS Provider Manual and/or KHS Credentialing Program Policy and Procedure.**

Last Name:		**First Name:**	
Degree:		**Specialty:**	
NPI #:		**Date of Birth:**	
Provider Type:	☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ Urgent Care ☐ Other:		
Group Name:		**Group TIN:**	
Credentialing Contact Name & Phone:		**Cred Contact Email Addr:**	
CAQH #		**Full CPPA**	☐ **Full CPPA Completed v.04.17.2025**

***Signatures must be wet signature or digitally/electronically verifiable such as Adobe or DocuSign**

Additional Documents REQUIRED:

The following documents must accompany your CAQH or CPPA application

- ☐ **Addendum A – Practitioner Rights**
- ☐ **Addendum B – Malpractice Information *settled cases only**
- ☐ **Addendum C – Practice Information**
- ☐ **Addendum D – Language Form**
- ☐ **Curriculum Vitae/Resume (mm/yy format)**
- ☐ **Copy of DEA Certificate or Signed Waiver**
- ☐ **Copy Certificate of Insurance (Provider & Group's name MUST be listed on coverage, certificate holder or roster)**
- ☐ **Supervising Physician Agreement (Applicable to APPs/Mid-Levels Only)**
- ☐ **Behavioral Health Questionnaire (Applicable to Mental/Behavioral Health Providers only)**

Submit Forms to:

Full Credentialing may take 90-120 days after receipt of all required information. To ensure timely submission and processing of your application please submit to the Credentialing Department's centralized email address:

EMAIL: Credentialing@khs-net.com Or Confidential FAX: (661) 473-7614 **V.1.2.2026**

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Practitioner's Practice Address:

Address: _____ City:_____ State:_____ Zip: _____

APPLICANT SIGNATURE (Digital or wet signature)**:** _____
PRINTED NAME: _____
DATE:_____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I: Practitioner Identifying Information		
Last Name:	First Name:	Middle:

II. Case Information			
Patient's Name:	Patient's Gender: ☐ Male ☐ Female		Patient's DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:

Location of incident: ☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify):
Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.)
Allegation:
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No
If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name:	Telephone Number:	Fax Number:

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) _____
PRINTED NAME: _____
DATE: _____

KHS Addendum C
Practitioner's Practice Information

Provider Name:		**Degree:**	
Specialty:		**Prov NPI #:**	
Group Name:		**Group TIN:**	

***LIST ALL LOCATIONS PROVIDER WILL RENDER SERVICES FOR KFHC BENEFICIARIES.**

IF BOTH ON-SITE & TELE-HEALTH/TELE-REMOTE - PLEASE INDICATE PROVIDER'S IN-PERSON WORK DAYS

Primary Address Location:		**City/State/Zip:**	
Office Hours:		**Provider Type:**	☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ UC

Are you accepting New Patients? ☐ Yes, Accepting New Patients ☐ No, Established Patients Only

Is your practice limited to certain ages? ☐ No ☐ Yes, ages limited to:_____

Appointment Options? ☐ No Telehealth (On-Site Only) ☐ Telehealth Only ☐ Both (On-Site & Telehealth) *

*If Both Please indicate In-Person Work Days: _____

FTE Percentage (40-hour work week) this provider is available to see pts at this location – The sum of percentages, from all sites, should not exceed 100%: ☐ 100 ☐ 80 ☐ 75 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 25 ☐ 10 ☐ Other:_____

Second Address Location:		**City/State/Zip:**	
Office Hours:		**Provider Type:**	☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ UC

Are you accepting New Patients? ☐ Yes, Accepting New Patients ☐ No, Established Patients Only

Is your practice limited to certain ages? ☐ No ☐ Yes, ages limited to:_____

Appointment Options? ☐ No Telehealth (On-Site Only) ☐ Telehealth Only ☐ Both (On-Site & Telehealth) *

*If Both Please indicate In-Person Work Days: _____

FTE Percentage (40-hour work week) this provider is available to see pts at this location – The sum of percentages, from all sites, should not exceed 100%: ☐ 100 ☐ 80 ☐ 75 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 25 ☐ 10 ☐ Other:_____

3rd Address Location:		**City/State/Zip:**	
Office Hours:		**Provider Type:**	☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ UC

Are you accepting New Patients? ☐ Yes, Accepting New Patients ☐ No, Established Patients Only

Is your practice limited to certain ages? ☐ No ☐ Yes, ages limited to:_____

Appointment Options? ☐ No Telehealth (On-Site Only) ☐ Telehealth Only ☐ Both (On-Site & Telehealth) *

*If Both Please indicate In-Person Work Days: _____

FTE Percentage (40-hour work week) this provider is available to see pts at this location – The sum of percentages, from all sites, should not exceed 100%: ☐ 100 ☐ 80 ☐ 75 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 25 ☐ 10 ☐ Other:_____

4th Address Location:		**City/State/Zip:**	
Office Hours:		**Provider Type:**	☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ UC

Are you accepting New Patients? ☐ Yes, Accepting New Patients ☐ No, Established Patients Only

Is your practice limited to certain ages? ☐ No ☐ Yes, ages limited to:_____

Appointment Options? ☐ No Telehealth (On-Site Only) ☐ Telehealth Only ☐ Both (On-Site & Telehealth) *

*If Both Please indicate In-Person Work Days: _____

FTE Percentage (40-hour work week) this provider is available to see pts at this location – The sum of percentages, from all sites, should not exceed 100%: ☐ 100 ☐ 80 ☐ 75 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 25 ☐ 10 ☐ Other:_____

KHS Addendum D

Practitioner and Staff Language Form

Practitioner Name:_____

If English is the only language spoken by Practitioner/Provider and your staff, please check this box: ☐ **English only**

PRACTITIONER	POSITION	LANGUAGE(S)	SPEAKING
	☐ Physician ☐ Provider ☐ NP/PA	1. 2. 3. 4. 5.	☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor
STAFF MEMBER	**RN, MA, or Office Staff**	1. 2. 3. 4. 5.	☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor
OTHER	**LANGUAGE SERVICES AVAILABLE AT OFFICE**		☐ Bilingual Staff / On-Site Interpreters ☐ KHS Interpreter Service ☐ Remote Video Service ☐ Telephone Interpreter Service

Evaluation Guidelines	**(A) Fluent**	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialism, and pertinent cultural preferences. Usually has received formal education in target language.
	(B) Good	Able to use the language fluently and accurately on all levels related to work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech. Bilingual staff rated as Good are encouraged to obtain an oral assessment of bilingual skills.
	(C) Fair	Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversations about work, school, and family. Has difficulty with vocabulary and grammar. Bilingual staff rated as Fair are encouraged to obtain an oral assessment of bilingual skills.
	(D) Poor	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to word entry level questions. May require slow speech and repetition. Bilingual staff rated as Poor are encouraged to use a qualified interpreter for communication with Limited English Proficient (LEP) patients. The definition of a qualified interpreter is listed in KHS Policy & Procedure 11.22-P.

If you need additional pages, please photocopy this form.