KERN HEALTH SYSTEMS

PROVIDER CHANGE REQUEST FORM

NOTE: All Providers contracted with KHS must notify KHS Provider Network Management of all changes according to contractual agreement & policy requirements. *NOTE: Tax ID & Group NPI Changes require new contract and/or amendment – Provider must notify KHS Contracting Dept at PRContracting@khs-net.com

Medi-Cal Enrollment REQUIRED:

KHS is required by federal law to ensure all new & currently contracted practitioners and providers are enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-For-Service Program. Organizational Facilities are also required to be enrolled in DHCS FFS Program AND pursuant to 22 CCR Section 51000.60 each established place-of-business requires all locations to be enrolled in Medi-Cal FFS . Please ensure that you maintain current & accurate information about yourself and your group as this data is submitted through PAVE and DHCS database portal.

Group Name:		**Group TIN:**	
Group NPI:		**Group Type:**	☐ PCP ☐ Specialist ☐ Multi/Dual

PROVIDER CHANGE/MAINTENANCE REQUEST:

☐ Provider Change (adding or terming a provider)

☐ Address Change (adding or terming an address location)

☐ Phone/Fax Change

Providers to be ADDED – Effective:

*NOTE Providers must be currently credentialed with KHS. Effective date may differ depending on timely submission requirements, FFS verification & entry into KHS databases. New providers must go through initial application process.

NAME:		**NPI:**	
NAME:		**NPI:**	

Providers to be TERMED – Effective:

*NOTE additional information may be requested by your PR Representative in compliance with State Regulations.

NAME:		**NPI:**	
NAME:		**NPI:**	

Address Changes – Effective:

*NOTE effective date may differ depending on timely submission requirements, FFS Status & entry into KHS databases

*NOTE Site Review required for new PCP Sites

Add New Location:				
	Phone		**Fax**	
Term Location:				

PHONE/FAX/OFFICE HOURS – Effective:

*NOTE effective date may differ depending on timely submission requirements, FFS verification & entry into KHS databases

New Phone:		**New Fax:**	
New Office Hours:			

Additional Documents REQUIRED:

☐ Existing Providers: Addendum C – Practice Information

☐ Professional Liability Coverage (Provider's name MUST be listed on coverage, certificate holder or attached listing)

☐ Supervising Physician Agreement Form (Physician Assistant (required), Nurse Practitioner under Supervision requirements)

By Signing below, KHS is authorized to make these changes:

Signature:_____**Printed Name:**_____ **Date:**_____

PLEASE EMAIL: Credentialing@khs-net.com OR Fax To: FAX: (661) 473-7614 **V1.06.2026**

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:_____

SUPERVISING PHYSICIAN AGREEMENT
(NON-PHYSICIAN MEDICAL PRACTITIONERS)

Complete and return to: Kern Health Systems
Attention: Credentialing
2900 Buck Owens Blvd
Bakersfield, CA 93308

Supervising Physician Information

Name: _____ Group Name: _____

State License No.: _____ NPI: _____

Type of Practice: _____ Provider Specialty: _____

Address: _____ City: _____ Zip: _____

Non–Physician Medical Practitioner Information *Form required for each separate Tax ID location.

Name: _____ License No.: _____ ☐ NP ☐ PA ☐ CNM

Address: _____ City: _____ Zip: _____

Primary Type of Service: ☐ Family/General Practice ☐ OB/GYN ☐ Internal Medicine ☐ Pediatrics

☐ Other: _____

Max. Hours worked per week: _____ / Physician Supervised Hours per week: _____

☐ Physician Assistant: I attest that my office/clinic is in possession of "Practice Agreements" for medical services and applicable supervisory guidelines, as required by Section 1399.540 and Section 1399.545(e), Title 16, California Code of Regulations, including new regulations approved under California Senate Bill 697, and are readily available for review upon request.

☐ Nurse Practitioners/CNM: I attest that my office/clinic is in possession of standardized procedures, as required by the Business & Professions Code, Nurse Practice Act (NPA) Section 2725 and further clarified in the California Code of Regulations, CCR 1480, and are readily available for review upon request.

I agree to comply with all applicable state and federal laws, regulations, standards that govern supervision of any and all activities related to non-physician medical practitioners. I further attest to have provided the legally required collaboration, consultation, and supervision consistent with my licensure; and agree to be available to the non-physician medical practitioner in person, or through electronic means to provide supervision to the extent required by California professional licensing laws, necessary instruction in patient management, consultation and referral to appropriate care/services by specialist physicians or other licensed health care professionals, as may be required. Any changes to the information given above must be reported to the Provider Relations Representative within 30 days of the effective date of the change.

Signature of Supervising Physician _____

Date _____