KERN HEALTH SYSTEMS

Non-Physician Medical Practitioner 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 additional documents required to begin the credentialing process.

CAQH Providers: Please indicate your CAQH Number AND return the required additional Addendums A-D.

CPPA Application: If using CPPA, application must be 2013 or newer version, completed in its entirety, AND return the required additional Addendums A-D.

Medi-Cal Enrollment REQUIRED:

Physician Providers must be enrolled in DHCS Medi-Cal FFS Program. KHS is required by federal law to ensure all new contracted providers are enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-For-Service Program, even if you will never submit claims for FFS members. Providers who enroll through the DHCS may render services to Medi-Cal FFS beneficiaries including Kern Family Health Care beneficiaries. NOT ENROLLED? If you are not yet enrolled, you must apply on-line at https://pave.dhcs.ca.gov/sso/login.do? prior to becoming eligible for participating in the KHS Network. ALREADY ENROLLED? Provide the provider's NPI and the Group NPI that is enrolled and approved in the DHCS Medi-Cal FFS Program. Please ensure that you maintain current & accurate information about yourself and your group as this data is submitted through PAVE and comprises the database DHCS requires the health plans to use to verify enrollment of the individual provider and groups.

Last Name:		**First Name:**	
Degree:		**NPI:**	
Specialty:		**Date of Birth:**	
Provider Type: ☐ PCP ☐ Specialist ☐ Dual ☐ ECM ☐ UC			
Group Name:		**Group TIN:**	
Credentialing Contact Name & Email:		**Group NPI:**	
CAQH # ☐		**Full CPPA**	☐ **Full CPPA Completed & Return**
If you are a CAQH provider, you do not need to complete the CPPA. Please ensure you have Global Authorization or have granted KHS authorization to obtain application from CAQH ProView.		**If you are not CAQH user & choose not to use CAQH Proview, you will be required to complete the CPPA in its entirety. Please ensure CPPA is version 2013 or newer and all signature pages are signed and dated. Signature must indicate digitally or electronically signed. Font/Printed Signatures are not accepted.**	

Additional Documents REQUIRED:

The following documents MUST be returned in addition to your CAQH # OR CPPA application:
Signatures must indicate digitally/electronically signed - Font/Printed signatures are not acceptable.

- ☐ **Addendum A – Practitioner Rights**
- ☐ **Addendum B – Professional Liability Actions Explained (if applicable or not included in CAQH)**
- ☐ **Addendum C – Practice Information/Race-Ethnicity Disclosure (Newly revised form attached)**
- ☐ **Addendum D – Language Form (Newly revised form attached)**
- ☐ **Supervising Physician Agreement Form (attached)**
- ☐ **Curriculum Vitae/Resume (with Work History in month/year format)**
- ☐ **Copy of DEA Certificate or Signed Waiver (if applicable or not included in CAQH)**
- ☐ **Copy of Professional Liability Coverage (Provider's name MUST be listed on coverage, certificate holder or attached listing)**

Submit Forms to:

To ensure timely submission and processing of your application please submit to the KHS Credentialing Department:
EMAIL: Credentialing@khs-net.com OR by FAX: (661) 473-7614

Sincerely,
KHS Credentialing Staff

V2.01.2025

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.

Healthcare Organization's Credentialing Department Address:

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

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____
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:**	

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

Telehealth Appointments? ☐ No Telehealth (On-Site Only) ☐ Both (On-Site & Telehealth) ☐ Telehealth Only

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

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

Telehealth Appointments? ☐ No Telehealth (On-Site Only) ☐ Both (On-Site & Telehealth) ☐ Telehealth Only

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

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

Telehealth Appointments? ☐ No Telehealth (On-Site Only) ☐ Both (On-Site & Telehealth) ☐ Telehealth Only

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

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

Telehealth Appointments? ☐ No Telehealth (On-Site Only) ☐ Both (On-Site & Telehealth) ☐ Telehealth Only

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

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:

Practitioner Race and Ethnicity Information (Optional - for health plan use only)

The following information is **voluntary** and will be used in provider directories to help members make informed choices and/or to help ensure that our network of providers meets the needs of our members. Providing race and/or ethnicity information on the credentialing application is entirely optional and refusal to provide this information will NOT subject the practitioner to adverse treatment. This information will NOT be considered in making any decisions regarding your credentialing.

Check here if you decline to disclose ☐

Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories ☐

Select one category or other: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic/Latino ☐ Other:

Other may include ethnicity, cultural background or descent including but not limited to: Armenian, Asian American, Asain Indian, Chinese, Cuba, Filipino, Indian, Iranian, Irish, Japanese, Korean, Middle Eastern, Native American, Native Hawaiian, Samoan, Navajo Nation, Nigerian, Pakistani, Persian, Puerto Rico, Taiwanese, Vietnamese, West Indian or Unknown.

Practitioner and Staff Language Form

Practitioner Name:____

Site Address:____

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

PRACTITIONER	POSITION	LANGUAGE(S)	SPEAKING
	☐ Physician ☐ Provider ☐ NP/PA	1. 2. 3.	☐ 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 ☐ Staff	1. 2. 3.	☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor
	☐ RN ☐ Staff	1. 2. 3.	☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor ☐ A-Fluent ☐ B-Good ☐ C-Fair ☐ D-Poor
	☐ RN ☐ Staff	1. 2. 3.	☐ 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

If you need additional pages, please photocopy this form.

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 2-3 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.

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 _____