



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.**

Medi-Cal Enrollment REQUIRED:

KHS is required by federal law to ensure all new & currently 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. Physician Providers must be enrolled in DHCS Medi-Cal FFS Program and groups must also be enrolled when there are “rendering providers” assigned under the group. 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:	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Multi/Dual
PROVIDER CHANGE/MAINTENANCE REQUEST:			
<input type="checkbox"/> Provider Change (adding or terming a provider) <input type="checkbox"/> Address Change (adding or terming an address location) <input type="checkbox"/> 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/Race-Ethnicity Disclosure (Newly revised form attached)
- ☐ Professional Liability Coverage (Provider’s name MUST be listed on coverage, certificate holder or attached listing)
- ☐ Supervising Physician Agreement Form (If Provider is PA, NP)

By Signing below, KHS is authorized to make these changes as noted on this Provider Change Request Form:

Signature: _____ Printed Name: _____ Date: _____

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

V1.05.2023

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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Dual <input type="checkbox"/> ECM <input type="checkbox"/> 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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Dual <input type="checkbox"/> ECM <input type="checkbox"/> 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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Dual <input type="checkbox"/> ECM <input type="checkbox"/> 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: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Dual <input type="checkbox"/> ECM <input type="checkbox"/> 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:

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other:	

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