

Provider Contract Request

Thank you for your interest in joining Kern Health Systems (KHS) provider network. Please complete this form and include copies of requested documents as indicated. Completion of this request form indicates your interest only. You may be contacted by a Provider Contract Specialist regarding next steps within 5-10 business days.

Facility/Provider:		
Name:		
Street Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Second Location:		
Name:		
Address:		
City:	State:	Zip:
Telephone #:	Fax #:	

Service / Specialty:
What area of Kern County do you service?
Tax ID:
NPI:

Main Contact:

Name: Phone Number: Email Address:



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

Is the clinic CPSP certified? Yes or No (If yes, please provide certification)

Is this clinic a federally designated Rural Health Clinic? Yes or 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 waver or registration? Yes or No If yes, have you applied for a CLIA number:

Are you an Ambulatory Surgery Center? Yes or No (If yes please submit a copy of your facilities accreditation.)

Please attach the following items to your email:

KHS Inquiry Form Current W9 MCAL Approval Letter CPSP Certification (if applicable) RHC Documentation (if applicable)

Contracting will reach out to confirm your request was received. Please feel free to attach any program outlines, brochures that may help us understand the services your facility can offer to our members.

Note: Completion of this form is not part of the credentialing application for network participation nor is it a guarantee a contract will be issued. The Credentialing process may take an additional 60-120 days. Please email this form along with requested documents to prcontracting@khs-net.com.