Letter of Interest – Specialist & Ancillary

Provider Network Management
Phone: **1-408-874-1788**
Fax: **1-408-362-9817**
Email: credentialing@scfhp.com

Santa Clara Family Health Plan's (SCFHP) mission is to provide high quality, comprehensive health care. Working in partnership with select providers, we act as a bridge between the health care system and those residents of Santa Clara County who need coverage.

Thank you for your interest in becoming an in-network provider. Contracts with SCFHP are for all lines of business – Medi-Cal, Healthy Kids HMO and Cal MediConnect, as applicable. Complete all applicable fields of this form and **return it along with the Provider's CV**, or applicable documentation, to SCFHP.

SCFHP requires all contracted providers to bill electronically.

Date: _____

Legal Business Name: _____

DBA: _____

Practice Address: _____

Contact Name/Provider Name: _____

Phone Number: _____ **Email:** _____

Type: ☐ Specialist ☐ Ancillary ☐ Other: _____

License #: _____ **DEA#:** _____

NPI #: _____ **TIN (*please include a copy of W-9*):** _____

Medi-Cal Provider #: _____ **Medicare Provider #:** _____

Date of Birth: _____

Hospital Affiliations: _____

Specialty: _____ **Certified:** ☐ Yes ■ No

Subspecialty: _____ **Certified:** ☐ Yes ■ No

Certifications: ☐ CCS ☐ CHDP ☐ Other: _____

Supervising/Covering Physician: _____

If you are completing this form for a medical group, please provide information for each provider in your group on the following page or provide an Excel spreadsheet with the same data fields.

Additional Providers/Physicians

Provider Name: _____

License #: _____ **DEA#:** _____

NPI #: _____

Medi-Cal provider #: _____ **Medicare Provider #:** _____

Date of Birth: _____

Hospital Affiliations: _____

Specialty: _____ **Certified:** ☐ Yes ☐ No

Subspecialty: _____ **Certified:** ☐ Yes ☐ No

Certifications: ☐ CCS ☐ CHDP ☐ Other: _____

Supervising/Covering Physician: _____

Provider Name: _____

License #: _____ **DEA#:** _____

NPI #: _____

Medi-Cal provider #: _____ **Medicare Provider #:** _____

Date of Birth: _____

Hospital Affiliations: _____

Specialty: _____ **Certified:** ☐ Yes ☐ No

Subspecialty: _____ **Certified:** ☐ Yes ☐ No

Certifications: ☐ CCS ☐ CHDP ☐ Other: _____

Supervising/Covering Physician: _____

Provider Name: _____

License #: _____ **DEA#:** _____

NPI #: _____

Medi-Cal provider #: _____ **Medicare Provider #:** _____

Date of Birth: _____

Hospital Affiliations: _____

Specialty: _____ **Certified:** ☐ Yes ☐ No

Subspecialty: _____ **Certified:** ☐ Yes ☐ No

Certifications: ☐ CCS ☐ CHDP ☐ Other: _____

Supervising/Covering Physician: _____