Letter of Interest – Primary Care Provider

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: ☐ PCP (see FSR*)

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.

*Facility Site Review (FSR) - *PCP Only*

The State of California Department of Health Care Services (DHCS) requires SCFHP to review all participating Primary Care Provider (PCP) sites to ensure compliance with State regulations. This review process is called the Facility Site Review (FSR). Please be sure to complete all sections of the Primary Care Facility Identification Form and the Facility Site Review (FSR) Worksheet for Providers when submitting your letter of interest.

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: _____