Letter of Interest

Provider Network Management

Phone: **1-408-874-1933**
Fax: **1-408-362-9817**
Email: contracting@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 Medi-Cal and Cal MediConnect, as applicable. Complete all applicable fields of this form and return it along with the Provider's Curriculum Vitae (CV), or applicable documentation, to SCFHP.

SCFHP requires all contracted providers to bill electronically.

Date:____________________ **Name of Person Completing This Form:** ____________________________________

Practice Information

Practice Name:____

DBA: ____

Practice Address:____

Phone Number:__________________________________ **Secure Fax:**______________________________

Practice Type: ☐ Solo ☐ Group ☐ Single Specialty ☐ Multi-Specialty ☐ Urgent Care ☐ Other:_____________

Tax ID Number (TIN):____________________ **Name Associated with TIN**:__________________________________

Contact Name:_________________________ **Contact's Phone Number**:____________________________________

Email Address:____

Provider/Physician Information

Provider Name: ____

Provider's Legal Name ***(as listed in state license)***: ____

Date of Birth: ___________________________________ **NPI #:**_______________________________________

Medicare Provider #:_____________________________ **Medi-Cal Provider #:** ______________________________

Have you ever voluntarily opted out of Medicare? ☐ Yes ☐ No

Have you ever been charged, suspended or otherwise sanctioned by Medicare, Medicaid or any state or federal program? ☐ Yes ☐ No

Your intent is to serve as: ☐ Primary Care Provider (see FSR*) ☐ Specialist ☐ Ancillary ☐ Urgent Care ☐ Hospital Based

Specialty:____ **Certified:** ☐ Yes ☐ No

Subspecialty:____ **Certified:** ☐ Yes ☐ No

Application Preference: ☐ Paper ☐ CAQH *(please provide CAQH ID #)*:____________________

*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. If applicable, the Facility Site Review (FSR) will be scheduled as part of SCFHP credentialing process.

Additional Providers/Physicians

If you are completing this form for a medical group, please provide information for each provider in your group using the fields below or provide an Excel spreadsheet identifying the same data fields.

Provider Name: ______________________________

Provider Legal Name ***(as listed in state license)*****:** ______________________________

Date of Birth: ____________________ **NPI #:** ____________________

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

Have you ever voluntarily opted out of Medicare? ☐ Yes ☐ No

Have you ever been charged, suspended or otherwise sanctioned by Medicare, Medicaid or <u>any</u> state or federal program? ☐ Yes ☐ No

Your intent is to serve as: ☐ Primary Care Provider (see FSR*) ☐ Specialist ☐ Ancillary ☐ Urgent Care ☐ Hospital Based

Specialty: ______________________________ **Certified:** ☐ Yes ☐ No

Subspecialty: ______________________________ **Certified:** ☐ Yes ☐ No

Application Preference: ☐ Paper ☐ CAQH *(please provide CAQH ID #):* ____________________

Provider Name: ______________________________

Provider Legal Name ***(as listed in state license)*****:** ______________________________

Date of Birth: ____________________ **NPI #:** ____________________

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

Have you ever voluntarily opted out of Medicare? ☐ Yes ☐ No

Have you ever been charged, suspended or otherwise sanctioned by Medicare, Medicaid or <u>any</u> state or federal program? ☐ Yes ☐ No

Your intent is to serve as: ☐ Primary Care Provider (see FSR*) ☐ Specialist ☐ Ancillary ☐ Urgent Care ☐ Hospital Based

Specialty: ______________________________ **Certified:** ☐ Yes ☐ No

Subspecialty: ______________________________ **Certified:** ☐ Yes ☐ No

Application Preference: ☐ Paper ☐ CAQH *(please provide CAQH ID #):* ____________________