Letter of Interest

Provider Network Operations
Phone: **1-408-874-1933**
Fax: **1-408-362-9817**
Email: contracting@scfhp.com

Your name: ____ Date: ______________________

Santa Clara Family Health Plan's (SCFHP) mission is to provide high quality, comprehensive healthcare coverage for those who do not have access to, or are not able to purchase, good healthcare at an affordable price. Working in partnership with providers, we act as a bridge between the healthcare system and those who need coverage.

Thank you for your interest in becoming an in-network provider. Contracts with SCFHP are for Medi-Cal and DualConnect (HMO D-SNP), as applicable. Complete this form and return it along with the provider's resume, or appropriate documentation, to SCFHP.

SCFHP requires all contracted providers to bill electronically. SCFHP prefers CAQH applications for credentialing. This online service simplifies the credentialing process, reduces paperwork, saves time, and is provided at no cost to you. Please be sure to grant SCFHP access to your CAQH application to avoid delays.

Practice information	
Practice name:	DBA:
Practice address:	
Phone:	Secure fax:
Email:	
Practice type: ☐ Solo ☐ Group ☐ Single specialty ☐ Multi-specialty ☐ Urgent care ☐ Other:____________________	
Tax ID number (TIN):	Name associated with TIN:
Contact name:	Contact's phone:
Contact's email:	

Provider information	
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: ☐ Paper ☐ CAQH – Please provide CAQH ID #: ______________________________ *Be sure to grant SCFHP access to your CAQH application. Paper application available upon request.*	

Santa Clara Family Health Plan™

Letter of Interest
Provider Network Operations
Phone: **1-408-874-1933**
Fax: **1-408-362-9817**
Email: contracting@scfhp.com

***Facility Site Review (FSR) – For primary care providers 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 FSR will be scheduled as part of SCFHP's 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 #2 information	
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 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: ☐ Paper ☐ CAQH – Please provide CAQH ID #____________________ *Be sure to grant SCFHP access to your CAQH application. Paper application available upon request.*	

Provider #3 information	
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 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: ☐ Paper ☐ CAQH – Please provide CAQH ID #____________________ *Be sure to grant SCFHP access to your CAQH application. Paper application available upon request.*	