

Thank you for your interest in becoming an in-network provider with Santa Clara Family Health Plan (SCFHP). SCFHP's mission is to improve the well-being of our members by addressing their health and social needs in a culturally responsive manner and partnering with providers and organizations in our shared commitment to the health of our community.

Contracts are for SCFHP Medi-Cal and SCFHP DualConnect (HMO-D SNP) as applicable. Please complete this form and return it via email or fax along with the provider(s) resume(s), or other appropriate documentation (e.g., W-9, Medi-Cal approval, Medicare approval, Provider Roster, if applicable) to SCFHP.

If you are completing this form for a medical group, please provide information for each provider in your group using this [Excel spreadsheet template](#) identifying the same data fields.

Questions? Please email the Contracting team at Contracting@scfhp.com.

Practice Information	
Legal name:	DBA:
Location name:	Email:
Address:	
Phone:	Secure fax:
Practice type: ☐ Individual ☐ Group ☐ Multi-specialty ☐ Other: _____	
Practice specialty/scope of services details (please describe):	
Does your provider group offer delegated credentialing?	☐ Yes ☐ No
Tax ID number (TIN):	Practice NPI:
Does your practice location(s) have any of these accessibility options? (select all that apply):	☐ B: Bed count ☐ E: Exam room ☐ EB: Exterior building ☐ IB: Interior building ☐ P: Parking ☐ R: Restrooms ☐ T: Exam table ☐ Wheelchair
Please indicate if your practice location(s) is(are) within one of the following areas of a public transportation route:	☐ 1 or more miles from public transport ☐ Less than 1 mile from public transport ☐ Less than 5 blocks from public transport ☐ Less than 1 block from public transport

Provider Information	
Provider name (as listed in state license):	
Date of birth:	NPI #:
Address where services will be provided:	
Medicare provider #:	Medi-Cal provider #:
<i>Note:</i> SCFHP requires all contracted providers to bill electronically and prefers credentialing through the Council for Affordable Quality Healthcare (CAQH) Provider Data Portal. This free online service streamlines the process and reduces paperwork. A paper application is available upon request. Please ensure to grant SCFHP access to your CAQH application to prevent delays. SCFHP requires that the CAQH re-attestation date be no more than fifteen (15) days old at the time of application submission.	
CAQH Provider Data Portal #:	Last CAQH re-attestation date:
Telehealth Services Provided: <i>Note:</i> Telehealth providers are required to be physically located in California, Oregon, Nevada, or Arizona to provide services. For more information, see: www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx	☐ In-person & Telehealth ☐ No Telehealth ☐ Telehealth only
Race (select all that apply): <i>Note:</i> Providing language, race, and ethnicity information is voluntary. If shared, this information will not be used for discrimination purposes in any employment, contracting, or credentialing processes. SCFHP may also determine the most appropriate timing for collecting this data to help prevent concerns related to discrimination.	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino origin ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other, please specify: _____ ☐ Prefer not to answer
Ethnicity (select all that apply): <i>Note:</i> Providing language, race, and ethnicity information is voluntary. If shared, this information will not be used for discrimination purposes in any employment, contracting, or credentialing processes. SCFHP may also determine the most appropriate timing for collecting this data to help prevent concerns related to discrimination.	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino origin ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other, please specify: _____ ☐ Prefer not to answer
Provider intent is to serve as a/an: <i>Note:</i> 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's credentialing process.	☐ Ancillary Provider ☐ Behavioral Health Provider ☐ Hospital-based Provider ☐ Primary Care Provider ☐ Specialist ☐ Other, please specify: _____

Provider Specialty:	Provider Subspecialty:
Does the provider have a current and unrestricted valid state professional license to practice in the State of California from the appropriate licensing board?	☐ Yes ☐ No
Does the provider have a valid CA Drug Enforcement Agency (DEA) certificate or Controlled Dangerous Substance (CDS) certificate?	☐ Yes ☐ No
Has the provider ever voluntarily opted out of Medicare?	☐ Yes ☐ No
Has the provider ever been charged, suspended or otherwise sanctioned by Medicare, Medicaid or <u>any</u> state or federal program?	☐ Yes ☐ No
Is the provider enrolled in the Vaccines for Children (VFC) program? SCFHP supports the enrollment of applicable providers in the VFC program to improve access to immunizations.	☐ Yes ☐ No
Physicians and Podiatrists only	
To which of these hospitals does the provider have admitting hospital privileges? (select all that apply) <i>Note:</i> SCFHP requires all MDs, DOs, and DPMs to have admitting hospital privileges at an SCFHP-contracted hospital. If a provider does not hold admitting privileges at one of these contracted hospitals, documentation of an admitting arrangement must be provided.	☐ El Camino Hospital – Los Gatos ☐ El Camino Hospital – Mountain View ☐ Good Samaritan Hospital ☐ Lucile Packard Children's Hospital ☐ O'Connor Hospital ☐ Regional Medical Center ☐ Saint Louise Regional Hospital ☐ Santa Clara Valley Medical Center ☐ Stanford Medical Center ☐ None of the above, Admitting arrangement only

By signing the below, I hereby attest that all information provided is true, accurate, and complete to the best of my knowledge.	
Printed name:	Title:
Phone:	Email:
Date:	Signature: