Trillium Community Health Plan

Health Net

NETWORK PARTICIPATION REQUEST FORM

PLEASE RETURN THIS FORM (S) AND A W-9 TO: NewProviderRequestBox@TrilliumCHP.com

Instructions to Physician/Provider:

- This form allows individual physicians or licensed healthcare professionals to request participation in our network(s)
- We will review your request to ensure you meet initial participation criteria; including maintaining admitting privileges at an in network hospital.
- Please type or print legibly. Incomplete forms will not be considered.
- A response to your request will generally be mailed within 30 business days of receipt of this form
- Please note that completion of the network participation form, credentialing application or CAQH application does not guarantee acceptance in the Health Plan provider network.
- Application processing and provider credentialing may take 90 to 120 days after receipt of all required information.

PHYSICIAN / PROVIDER / PRACTICE INFORMATION

Medical Group Name and/or Practitioner name:

Billing Address:			Suite:
City:	State:	County:	Zip:
Primary Street Address:			Suite:
City:	State:	County:	Zip:

Contract Contact:______________________ Telephone No:________________________ Email:______________________________	Practice Phone:_________________________ Practice Fax:__________________________ Practice Specialty:_______________________	Contract business interest: ☐Commercial ☐Medicare ☐Medicaid
Are you registered with CAQH? ☐Yes: Please list ID__________________ ☐No	Tax Identification # ____________________ (Attach copy of W-9) Billing GNPI#_________________________	DMAP Number:___________________ PTAN Number:____________________
Applying as: ☐PCP ☐Specialist ☐Allied Health Professional	Information about practitioners: How many MD, DO's in the office?____ How many Allied or Mid-Level practitioners in the office?______________________ What is your capacity for new patients?____________________________________ Are you considered a PCPCH? ___________ If yes what tier?___________	

☐I am a solo practitioner billing under an individual tax ID ☐We are a group practice with multiple providers billing under a single tax ID number (If yes, please provide the medical group name below and attach a physician listing.)	Does your practice offer Telehealth Services? ☐Yes ☐No

Please list out your program offerings with emphasis on the services that you provide. Please include your website.

Please List Your Hospital Affiliations:

Please List Covering Physicians:

Correspondence/Credentialing/Billing Address

Credentialing contact:	Credentialing Phone:	Credentialing Email

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