

Provider Data Form

To begin the credentialing process for Health Net Insurance, please use this simple, standardized form.

DATE:				
Last Name:		First Name:		Middle Initial:
Date of Birth:		Primary Telephone No.:		
Primary Office Street Address:			Suite #:	
Primary Office City:		State:	County:	Zip:
Provider Type (MD, DO, DPM, PA, APRN, OT, etc) :				
Specialty:		Applying As: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health Professional <input type="checkbox"/> Hospitalist		
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, board name:		
You are required to be registered with CAQH prior to sending this back to the CSMS-IPA. If you are not registered please go to http://caqh.geoaccess.com		CAQH Provider ID:		

Please provide the following additional information.

Primary Fax No.:		Email Address:	
Social Security No.:		DEA Certificate No.:	
State License No.:		Licensed State:	
UPIN:		Tax ID:	
Medicare No.:		NPI No.:	
*Number must be supplied in order to be participating in Health Net's Medicare network		National Provider Identifier	

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with any of the above organizations. If applicable, please contact the health plan directly to request contracting information.



Health Net

The following information is required by Health Net's Network Management Dept.

Physician/Provider Name:

Group Name:

List Other Providers in Group:

Location 2:

Phone #:	Contact:
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Location 3:

Phone #:	Contact:
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Location 4:

Phone #:	Contact:
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****If you would like the credentialing packet sent to an address other than the "Primary Office Address", please make a note of that.**