Fax to: Health Net Federal Services, LLC **Fax number: 1-844-224-0381**

Fill out the information below and use this page as a fax cover sheet for your Provider Information Form (PIF). We offer a fillable PDF version of this form at **www.hnfs.com** > *Join our T2017 Provider Network.*

Note: PIFs received without this fax cover sheet as the first page of your fax **will not** be processed.

Do not fax the "Dear Applicant" page of the form.

If you are faxing more than one PIF, you **must** include a fax cover sheet with each PIF.

Tax Identification Number
Type I National Provider Identifier (NPI)
Social Security Number
CAQH ID (if applicable)

Dear Provider Applicant:

Thank you for your interest in participating in the Health Net Federal Services, LLC (HNFS) TRICARE Provider Network. HNFS utilizes the Council for Affordable Quality Healthcare (CAQH®) Universal Credentialing DataSource® for the application and credentialing process. CAQH is a not-for-profit alliance of the nation's leading health plans, including HNFS. CAQH has developed a free, secure, online database for the collection of provider credentialing data where providers submit one standard application to a single database. All authorized health plans can access the information at any time.

Please complete and return the attached Provider Information Form (PIF) so we may add you to HNFS' roster of CAQH providers. If you do not already have one, we will alert CAQH to assign you a provider ID and send it to you, along with instructions for how to set up your CAQH profile. Once we receive the completed PIF, **you will have up to thirty (30) days to complete your CAQH online application**; failure to do so will result in the discontinuation of the credentialing process with HNFS until you resubmit a new PIF.

HNFS' policies require the following additional requisites for individual provider applicants to ensure we maintain quality of care standards for patients. Please be aware these are minimum standards. Failure to meet minimum standards may render an applicant ineligible for participation in the network. Network providers must be recredentialed every three years to maintain network status.

Note: Employees/contractors of contracted corporate service providers do not need to be credentialed. The full credentialing process may take anywhere from 60 days to 180 days from the time we receive a complete application, depending on third party responses to our inquiries. When the credentialing process is complete, you will receive written notification from HNFS of the results. If you are approved for TRICARE network participation, we will send a fully executed copy of your participation agreement.

Thank you for your interest in the TRICARE program. We look forward to partnering with you in providing health care services to our active duty service members, retirees and their families.

Health Net Federal Services
Credentialing Department

Steps for submission:

1. Have an existing network participation agreement on file, or attach a new HNFS agreement.
2. Complete and sign the PIF and Credential Attestation, Authorization and Release.
3. Return PIF and all relevant materials to the address provided at the footer of your Provider Agreement cover letter.
4. If you do not already have a CAQH provider ID, we will alert CAQH to assign you one and send it to you, along with instructions for how to set up your CAQH profile.
5. Once you receive notification from CAQH that you have been added to the HNFS roster, log on to CAQH, complete the CAQH application and ensure you authorize HNFS to access your information.
6. Ensure all CAQH information is complete and current, **including an image of Professional Liability Insurance.**
7. When the credentialing process is complete, we will send you written notification of the results.

HEALTH NET FEDERAL SERVICES

TRICARE®

Provider Information Form (PIF)

This form should be completed electronically or legibly printed in blue or black ink. All fields are required, unless otherwise noted.

Note: Behavioral health providers should not complete this form. Contact MHN at 1-800-541-3353 or visit www.mhn.com.

Identifying Information *(Must match CAQH application)*

Last Name	First Name	MI	Title/Degree

DOB	☐ Male ☐ Female	Individual Medicare ID Number

SSN (No dashes)	Individual NPI (Type I) (No dashes)	CAQH ID (If applicable)

Primary Directory Specialty	Secondary Directory Specialty (If applicable)

Email Address

Will you accept Civilian Health and Medical Program of the Department of Veterans Affairs patients? ☐ Yes ☐ No

Will you accept assignment of Department of Veterans Affairs patients? ☐ Yes ☐ No

Are you participating as a primary care manager (PCM), and/or specialist (Spec), or as a hospital-based specialist? ☐ PCM ☐ Spec ☐ Hospital-based specialist

Are you accepting new patients? ☐ Yes ☐ No

Practice Information *(Must match CAQH application)*

Practice Name

Primary Office Physical Address	City	State	ZIP

Primary Office Phone	Primary Office Referral /Authorization Fax	Primary Office Fax

Practice/Office Manager Name	Practice/Office Manager Phone

Primary Billing Address	City	State	ZIP

TIN/EIN	NPI (Type II)	Billing Phone	Billing Fax

Do you currently file medical claims electronically? ☐ Yes ☐ No

Does your office meet all state and federal handicap access requirements? ☐ Yes ☐ No

Credentialing Point of Contact Information

Point of Contact Name	Email Address	Hours Available

Mailing Address	☐ Check if mailing address is same as primary office address	City	State	ZIP

Phone	Fax

Important Information—Criminal History Review

As part of the Managed Care Support Contract for the TRICARE program in the T2017 West Region, HNFS is required to perform Criminal History Reviews of certain physicians and non-physician network providers. Contractors may search federal, state and county records in performing criminal history checks and may subcontract for these services.

Criminal History Reviews are performed on physicians with anomalies in their licensure history (four or more active and/or expired licenses) or who have been disciplined. Contractors also shall perform Criminal History Reviews on all non-physician providers who practice independently, and who are not supervised by a physician.

HNFS has chosen to subcontract for these services. Please note, a credit history is not being performed; however, as our reviews are considered investigative, they fall under the requirements of the Fair Credit Reporting Act. Therefore, this information has been provided as part of the Fair Credit Reporting Act.

A Summary of Your Rights Under the Fair Credit Reporting Act can be found online at:
http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre35.pdf.

Important Information—Investigative Consumer Report Disclosure

In connection with your employment or application for employment (including contract for services), an investigative consumer report and consumer reports, which may contain public record information, may be requested. These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drug/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency or other source, which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies that maintain such records. You have the right to receive, upon a written request made within 60 days, a complete and accurate disclosure of the nature and scope of the investigation requested. You have the right to make a request to AbsoluteHire, upon proper identification, for the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that AbsoluteHire has previously furnished within the two-year period preceding your request. AbsoluteHire may be contacted by mail at 101 Creekside Ridge Ct., 2nd Floor, Riverside, CA 95678 or by phone at 1-800-943-2589.

Credentials Attestation, Authorization and Release

I acknowledge and agree that Health Net Federal Services, LLC (HNFS) has a valid interest and legal requirement to obtain and verify information concerning my professional competence, therefore:

1. I authorize HNFS and/or any entity with which it may contract for verification services to consult with hospital administrators, physicians, malpractice carriers and other persons or entities to obtain and verify information concerning my professional competence, character, moral and ethical qualifications. I release HNFS and its employees, managers, agents and consulting committees form any and all liability for their acts performed in good faith and without malice in obtaining, verifying and evaluating such information.

2. I consent to and authorize the release by any person or entity to HNFS of all information and documents that may be relevant to an evaluation of my professional competence, character, morality and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence, suspension or curtailment of medical or surgical privileges (including malpractice claims and/or coverage). I hereby release any such person or entity providing such information from any and all liability for doing so. If I have contracted with a medical group, Individual Physician Association or similar entity as a participating provider with HNFS or such other health plans, they also may receive the credentialing information or quality assurance data relating to me.

3. I understand that I have the burden and legal responsibility of providing adequate information to HNFS to demonstrate my professional competence, character, moral ethics and other qualifications.

4. I attest to the fact the information submitted by me in this application is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the HNFS Provider Network, or be subject to applicable state or federal penalties for perjury.

5. If any material changes occur affecting my professional status, I agree to notify HNFS within five days, as per Section 2.16 of the Professional Provider Agreement.

6. I have attached my Professional Liability Insurance (PLI) with this form, or I have posted a current copy of my PLI on CAQH, which expires:

Note: Application will be returned if there is no current copy of PLI on CAQH.

Date of Professional Liability Insurance Expiration

Provider Name
(Type or use block print)

Provider Signature

Date

Note: Must be signed and dated within 30 days of submittal.

Print Form