Inland Empire Health Plan

Letter of Interest (LOI) Form
* Ancillary/Specialty Programs only *

Application Instructions:

- Please note completion of this form does not guarantee acceptance in the IEHP Direct Provider Network. IEHP will review your request to ensure you meet initial participation criteria.
- Please type or print legibly. Incomplete forms will be returned and not considered.

Submission Instructions:

- Send the following forms to jointhenetwork@iehp.org:
  - Completed LOI Form
  - W-9 Form
  - Proof of Medi-Cal enrollment OR proof of Medi-Cal application submission
    - Please refer to our website at https://www.providerservices.iehp.org/en/join-our-network/screening-and-enrollment for additional information.

PROVIDER INFORMATION

Provider Name: _____

Address: _____

City: _____ Zip: _____

TIN: _____ Group NPI: _____

Contract Type: -select-

Ancillary Specialty/Specialty Program: _____

Contact Person: _____ Contact Phone #: _____

Contact Email: _____ Referral Fax #: _____

Requested Line of Business: ☐ Medi-Cal ☐ Medicare ☐ Open Access only ☐ Covered CA

Service Area: (select all that apply)
- ☐ Corona/Temecula/Hemet
- ☐ High Desert
- ☐ Low Desert
- ☐ Mohave Valley
- ☐ Palo Verde Valley
- ☐ Riverside
- ☐ San Bernardino Proper
- ☐ West San Bernardino

IEHP HISTORY

Please provide any relevant history with IEHP related to the entity's TIN or associated providers: _____

_____

_____

_____

IE HP
Inland Empire Health Plan

TRANSPORTATION ONLY

Approved Medi-Cal Services: ☐ NMT ☐ NEMT

Available Vehicles:
(select all that apply)

☐ Sedan How Many? _____
☐ Wheelchair Van How Many? _____
☐ Gurney/Liter Van How Many? _____

Service Zip Codes: _____
_____
_____