



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 Response-

Ancillary Specialty/Specialty Program: _____

Contact Person: _____ Contact Phone #: _____

Contact Email: _____ Referral Fax #: _____

Requested Line of Business: Medi-Cal Medicare Covered CA Open Access (PCP only)

Service Area: Corona/Temecula/Hemet

(select all that apply) High Desert

 Low Desert

 Mohave Valley

 Palo Verde Valley

 Riverside

 San Bernardino Proper

 West San Bernardino

ADDITIONAL LOCATION INFORMATION

Practice Name: _____

Practice Address: _____

Practice City: _____ Practice Zip: _____

Office Hours: _____ Phone #: _____

Is this a Safety Net clinic? Yes No If Yes, Please Specify: _____



IEHP HISTORY

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

TRANSPORTATION ONLY

Approved Medi-Cal Services: NMT NEMT

Available Vehicles:	Sedan	How Many? _____
(select all that apply)	Wheelchair Van	How Many? _____
	Gurney/Liter Van	How Many? _____

Which Advanced Transportation Management System (ATMS) do you use? _____

Service Zip Codes: _____

