Inland Empire Health Plan

Provider Network Expansion Fund Program Application

Thank you for your interest in the Network Expansion Fund. Please refer to the **Network Expansion Fund Program Description** on the IEHP website (IEHP.org> Providers>Join our Network>Provider Network Expansion Fund) for information regarding the program.

Submission Instructions:

- Please note that the completion of this application does not guarantee approval for funding for the Network Expansion Fund.
- Please submit one application per candidate.
- Incomplete applications will be rejected. This includes application, CV, and justification letter.
  - Include the most recent CV/Resume for requesting provider.
  - Include justification letter, providing specific information and data to justify why the requested position should be funded, including but not limited to caseloads of current providers at practice, membership capacity, access times for appointments, etc.
- To apply for funding complete the application below and email to Provider Network Analyst's Team at NEFProgram@iehp.org.

EMPLOYING/CONTRACTING ENTITY INFORMATION	
Entity Name: _____	Contact Person: _____
Entity Address: _____	Contact Phone #: _____
Entity City & Zip: _____	Contact Email: _____
Entity TIN: _____	Contracted with IEHP: ☐ **Yes** ☐ **No**
POSITION TO BE FUNDED	**PROVIDER PRACTICE LOCATION INFORMATION**
Provider Type: ☐ APP ☐ PCP ☐ SPEC	Practice Address 1: _____
Provider Name: _____	Practice City 1: _____ Practice Zip 1: _____
Provider NPI: _____	Practice Address 2: _____
Provider Specialty: _____	Practice City 2: _____ Practice Zip 2: _____
Provider Hire Date: _____	Practice Address 3: _____
Provider Working Hours: _____	Practice City 3: _____ Practice Zip 3: _____
Supervising Physician (APP ONLY): _____	