

Letter of Interest (LOI) Form

Application Instructions:

- Thank you for your interest in becoming an IEHP Direct Network Provider.
- 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 <u>OR</u> 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.

	CONTRACTING ENTITY INFORMATION	
Entity Name:		
Entity Address:		
Entity City:	Entity Zip:	
Entity TIN:	Group NPI:	_
Contact Person:	Contact Phone #:	_
Contact Email:		
Contract Type: Select Respo	onse	
Requested Line of Business:	Medi-Cal Medicare Open Access only Covered CA	
List Specialties/Services:		
Do you offer telehealth servi	ices? Select Response	
I am a solo practitione	er billing under an individual Tax ID Number	
·	er billing under an individual Tax ID Number ce with multiple Providers billing under a single Tax ID Number*	
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We are a group practic	ce with multiple Providers billing under a single Tax ID Number* CONTRACTING PRACTICE INFORMATION	
We are a group practice Practice Name:	ce with multiple Providers billing under a single Tax ID Number* CONTRACTING PRACTICE INFORMATION	
We are a group practice Practice Name: Practice Address:	ce with multiple Providers billing under a single Tax ID Number* CONTRACTING PRACTICE INFORMATION	
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Practice Name: Practice Address: Practice City: Referral Fax #: First Name: NPI:	CONTRACTING PRACTICE INFORMATION Practice Zip: Group NPI: CONTRACTING PROVIDER INFORMATION MI: Last Name:	-



*If you are a group practice with multiple Providers billing under a single Tax ID Number, please utilize the following section to list any additional Providers to be added to this contract

ADDITIO	NAL PROVIDER(S) & PRACTICE LOCATION(S)
First Name:	MI: Last Name:
	License #:
	Sub-specialties:
	Hospital Affiliations:
Check if same as contracting prac	
Practice Name:	
	Practice Zip:
First Name:	MI: Last Name:
	License #:
Specialty:	Sub-specialties:
Age Range:	Hospital Affiliations:
Check if same as contracting prac	tice information above
Practice Name:	
	Practice Zip:
First Name:	MI: Last Name:
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