A Public Entity

Inland Empire Health Plan

Ancillary Provider Network Participation Request Form

This form should be filled out for the following Provider types:

- Ambulance
- Ambulatory Surgery Center (ASC)
- Dialysis Facilities
- Durable Medical Equipment (DME)
- Hearing Aid Providers
- Home Health
- Home Infusion
- Hospice
- Laboratory
- Longer Term Acute Care (LTAC)
- Radiology/MRI/PET
- Skilled Nursing Facilities (SNF)
- Sleep Study Centers
- Urgent Care Centers*

***** *Urgent Care Centers need to fill out a Credentialing Application (see PCP/Specialist link) and must complete an UCC Evaluation Minimum Qualification Form.*

Instructions to Ancillary Provider:

- This form allows Ancillary Providers to request participation in the IEHP Direct Provider Network.
- You should complete the form and email it directly to IEHP per instructions below.
- IEHP will review your request to ensure you meet current requirements for participation, as well as filling network needs for your specialty.
- Please note that acceptance of a Provider's request form does not guarantee acceptance into the IEHP Direct Provider Network.

Provider Information			
Provider Name			
Street Address			**Suite**
City	**State**	**Zip Code**	
Telephone #	**Referral Fax #**		
Tax ID #(s)			
NPI #			
Email Address			
Ancillary Specialty(s)			
Medicare Certified	☐ **Yes**	☐ **No**	
Person to Contact Regarding this Request			
Contact Phone #	**Contact E-mail Address**		

PLEASE RETURN THIS FORM AND A W-9 TO: contract@iehp.org