California Participating Practitioner Application Checklist

CONIFER HEALTH SOLUTIONS®

Name:	Specialty:	
	CAQH **#**	**CPPA V.2013** W:\Credentialing\Credentialing Applications
Completed Practitioner Application Signatures to be within 120 days-Stamped signatures not acceptable.	☐	☐
Hospital Affiliations If no current affiliations, coverage arrangement should be provided.	☐Pg. 12	☐Pg. 7
Work History Minimum requirement is 5 years of work history in month/year format. If there are any gaps exceeding 6 months, please provide explanation.	☐Pg. 13	☐Pg. 9
HIV/AIDS Specialist Designation Identify designation, sign, and date.	☐W:\Credentialing\Credentialing Applications	☐Pg. 12
Attestation All questions to be answered. If your answer to any of the following questions is “Yes”, please provide full details on a separate sheet of paper.	☐Pg. 16-17	☐Pg. 13-14
Information Release Form to be reviewed, signed and dated.	☐	☐Pg. 15
Addendums **A**. Practitioner Rights **B**. Professional Liability Action Explained Forms to be completed, signed and dated.		☐
Supporting Documentation Copies of the following documents are to be included.		
• Medical License	☐	☐
• DEA Certificate (if applicable)	☐	☐
• Certificate of Insurance (1-3 Million)	☐	☐
• Board Certificates (if applicable)	☐	☐
• Curriculum Vitae CV	☐	☐
• W9 W:\Credentialing\Credentialing Applications	☐	☐
Internal use only		
Contract Status Address and TIN on application must match contract locations and TIN.	Check One	
Provider contract semi executed.	☐	
New group contract provider listed on exhibit, and semi executed.	☐	
Existing group contract provider amendment created.	☐	

Providers Signature　　　　　　　　　　Date

Provider Practice Signature　　　　　　　Date

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HIV Attestation

☐No, I do not wish to be designated as an HIV/AIDS specialist.

☐Yes, I do wish to be designated as an HIV/ AIDS Specialist based on the below criteria:

☐I am credentialed as an “HIV Specialist” by the American Academy of HIV Medicine.

OR

☐I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member of the American Board of Medical Specialties.

OR

☐I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy.

OR

☐In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months I have completed board certification in Infectious Disease.

OR

☐In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine.

OR

☐In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print)____**Date** _

Signature____**License #** ______________

CERTIFICATE OF NEW PROVIDER TRAINING

I have received, reviewed and completed the New Provider Training from Health Net,* on behalf of CalViva Health. I understand the essential components of CalViva Health's Medi-Cal plan, including basic information about public health programs available to CalViva Health Medi-Cal members, CalViva Health's quality improvement program, and interpreter services and provider tools to care for diverse populations.

In addition, I understand my responsibilities related to CalViva Health's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and CalViva Health. I understand how to access and find information about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals, located on the provider website under *Working with Health Net > Contractual > Policy Library > Go to the Provider Library.*

The training was completed: (Must check one)

☐ Self-guided (Online/hard copy)

☐ Instructor-led (Online/in-person)

Provider name (PRINT)	Tax identification number (TIN)
Provider signature	Date training completed
Telephone number	Email address

In order to complete the enrollment of your contract, sign, date and complete this certification, and submit with your contract documents. Note: Failure to complete this certification may result in a delay in becoming an active provider for CalViva Health and Health Net.

Rev 5/2019

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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