Trillium Community Health Plan

Health Net

NETWORK PARTICIPATION REQUEST FORM

PLEASE RETURN THIS FORM (S) AND A W-9 TO: NewProviderRequestBox@TrilliumCHP.com

Instructions to Physician/Provider:

- This form allows individual physicians or licensed healthcare professionals to request participation in our network(s)
- We will review your request to ensure you meet initial participation criteria; including maintaining admitting privileges at an in network hospital.
- Please type or print legibly. Incomplete forms will not be considered.
- A response to your request will generally be mailed within 30 business days of receipt of this form
- Please note that completion of the network participation form, credentialing application or CAQH application does not guarantee acceptance in the Health Plan provider network.
- Application processing and provider credentialing may take 90 to 120 days after receipt of all required information.

PHYSICIAN / PROVIDER / PRACTICE INFORMATION

Medical Group Name and/or Practitioner name:			
Billing Address:			Suite:
City:	State:	County:	Zip:
Primary Street Address:			Suite:
City:	State:	County:	Zip:
Contract Contact:_____ Telephone No:_____ Email:_____	Practice Phone:_____ Practice Fax:_____ Practice Specialty:_____	Contract business interest: ☐Commercial ☐Medicare ☐Medicaid	
Are you registered with CAQH? ☐Yes: Please list ID_____ ☐No	Tax Identification # _____ (Attach copy of W-9) Billing GNPI#_____	DMAP Number:_____ PTAN Number:_____	
Applying as: ☐PCP ☐Specialist ☐Allied Health Professional	Information about practitioners: How many MD, DO's in the office?_____ How many Allied or Mid-Level practitioners in the office?_____ What is your capacity for new patients?_____ Are you considered a PCPCH? _____ If yes what tier?_____		
☐I am a solo practitioner billing under an individual tax ID ☐We are a group practice with multiple providers billing under a single tax ID number (If yes, please provide the medical group name below and attach a physician listing.)		Does your practice offer Telehealth Services? ☐Yes ☐No	
Please list out your program offerings with emphasis on the services that you provide. Please include your website.			
Please List Your Hospital Affiliations:			
Please List Covering Physicians:			

Correspondence/Credentialing/Billing Address

Credentialing contact:	Credentialing Phone:	Credentialing Email

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New BH Provider Services and Specialty Checklist

Thank you for your interest in joining our BH provider network to serve Trillium Medicaid members. The services and specialty checklist below will assist us in the contracting process, ensure your services are listed accurately in our directory and support BH referrals for members to our contracted network. **Check all that apply:**

Populations you serve: ages

☐Early Childhood (0-6)
☐Children (6-12)
☐Youth (12-17)
☐Young Adults (17-24)
☐Adults (18-64)
☐Seniors (60 and over)

BH Service Delivery Setting:

☐BH OP - Individual Practitioner
☐BH OP – Group Practice
☐BH OP – Agency/Clinic with COA
☐BH OP – Agency/Clinic without COA
☐BH Res – Facility based setting
☐BH Integrated – PCP integrated clinic

BH Service Delivery Mode:

☐BH OP – in person, office based
☐BH-OP – community based, in home
☐BH OP – telehealth via phone
☐BH OP – telehealth via video
☐BH Res – in person, face-to-face services

BH Service Delivery Format:

☐Individual
☐Group
☐Family/Couples

BH Certification and License:

☐COA: OHA BH Certificate of Approval
☐OHA licensed MH facility
☐OHA licensed SUD facility
☐Other BH certification, specify:_____
☐Licensed clinical practitioner/s
☐Licensed nurse practitioner
☐Licensed psychiatrist
☐Non-licensed practitioner
☐Tribal Health certified
☐DMAP ID number

Populations you serve: culturally specific and groups with specialized needs:

☐African American
☐Bilingual ☐Bicultural
☐American Indian/Alaska Native
☐Bilingual ☐Bicultural
☐Asian/Pacific Islander
☐Bilingual ☐Bicultural
☐Hispanic/Latino
☐Bilingual ☐Bicultural
☐Eastern European
☐Bilingual ☐Bicultural
☐Immigrant populations, specify:_____
☐Bilingual ☐Bicultural
☐Children/Youth in foster care
☐LGBTQ+
☐Pregnant/Postpartum
☐Women's specific
☐Men's specific
☐Dual Diagnosis
☐Houseless population
☐Services for members who are deaf
☐SPMI/SMI (Serious Mental Illness)

BH Therapy Type and Services:

☐ACT: Acceptance/Commitment
☐CBT: Cognitive Behavioral
☐DBT: Dialectical Behavioral
☐Dual Diagnosis: MH and SUD concurrent
☐EMDR: Eye Movement Desensitization
☐Motivational: MI/MET
☐Other Psychotherapy, specify: _____
☐Medication management
☐Psychiatric services
☐Psychoeducation
☐SUD specific services
☐Services in American Sign Language (ASL)
☐Animal assisted therapy
☐Eating disorder services
☐TMS - Transcranial Magnetic Stimulation
☐Care Coordination
☐Case Management
☐Crisis Services

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