

## How to Join the Network

Joining our network begins with submission of the Provider Inquiry Form (*utilize the web-based submission form or print the attached form below*).

Note that this is a multi-step process:

1. Network Adequacy Workgroup meets monthly to review provider inquiries for participation. You will be notified of the Workgroup decision.
2. Based on network need, an invitation to join the network will be sent with a contract and request for credentialing application and documents. Once all documents are received, the verification process begins and usually takes about 6-8 weeks. Upon approval from the Credentialing Committee you will receive a welcome packet, which includes the effective date of participation in the network.

**Practitioners must be contracted and credentialed prior to providing services to Stanford Health Care Advantage members.**

**PROVIDER INQUIRY FORM**Email: [providerrequest@stanfordhealthcareadvantage.org](mailto:providerrequest@stanfordhealthcareadvantage.org)

Date: \_\_\_\_\_

Please fill out form in its entirety. Missing information will prevent consideration by the Network Adequacy Workgroup. If you do not have requested ID numbers, please indicate pending or no number. Based on network need, we will send you an invitation that includes a contract and request for completed credentialing application and documents. Upon receipt of a COMPLETE application and signed contract, the verification process will begin. This process takes approximately 6-8 weeks. Upon Credentialing Committee approval, we will send you a welcome letter.

**YOU MUST BE CONTRACTED AND CREDENTIALLED PRIOR TO PROVIDING SERVICES TO OUR MEMBERS.**

Individual Provider Name: \_\_\_\_\_

Facility/Group Name: \_\_\_\_\_

Provider Specialty: \_\_\_\_\_

Group Name (if applicable): \_\_\_\_\_

Tax ID #: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact Person's Phone: \_\_\_\_\_

Contact person email: \_\_\_\_\_

Primary Office Location: \_\_\_\_\_

Phone #: \_\_\_\_\_

FAX #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Additional Office location(s):

Phone #: \_\_\_\_\_

FAX #: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Network Adequacy Workgroup DECISION: APPROVE DECLINE DATE: \_\_\_\_\_

REASON: \_\_\_\_\_