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 OR 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 -

Requested Line of Business: ☐ Medi-Cal ☐ Medicare ☐ Open Access only ☐ Covered CA

List Specialties/Services: _____

Do you offer telehealth services? - select -

◯ I am a solo practitioner billing under an individual Tax ID Number

◯ We are a group practice with multiple Providers billing under a single Tax ID Number*

CONTRACTING PRACTICE INFORMATION

Practice Name: _____

Practice Address: _____

Practice City: _____ Practice Zip: _____

Referral Fax #: _____ Group NPI: _____

CONTRACTING PROVIDER INFORMATION

First Name: _____ MI: _____ Last Name: _____

NPI: _____ License #: _____

Specialty: _____ Sub-specialties: _____

Age Range: -select or type- Hospital Affiliations: _____

IEHP
Inland Empire Health Plan

**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*

ADDITIONAL PROVIDER(S) & PRACTICE LOCATION(S)

First Name: ____________________ MI: ____ Last Name: ________________________
NPI: ________________________ License #: ________________________
Specialty: ________________________ Sub-specialties: ________________________
Age Range: -select- ____________ Hospital Affiliations: ____________________________
☐ Check if same as contracting practice information above
Practice Name: ____
Practice Address: ____
Practice City: ________________________ Practice Zip: ______________________

First Name: ____________________ MI: ____ Last Name: ________________________
NPI: ________________________ License #: ________________________
Specialty: ________________________ Sub-specialties: ________________________
Age Range: -select- ____________ Hospital Affiliations: ____________________________
☐ Check if same as contracting practice information above
Practice Name: ____
Practice Address: ____
Practice City: ________________________ Practice Zip: ______________________

First Name: ____________________ MI: ____ Last Name: ________________________
NPI: ________________________ License #: ________________________
Specialty: ________________________ Sub-specialties: ________________________
Age Range: -select- Hospital Affiliations: ____________________________
☐ Check if same as contracting practice information above
Practice Name: ____
Practice Address: ____
Practice City: ________________________ Practice Zip: ______________________

First Name: ____________________ MI: ____ Last Name: ________________________
NPI: ________________________ License #: ________________________
Specialty: ________________________ Sub-specialties: ________________________
Age Range: -select- Hospital Affiliations: ____________________________
☐ Check if same as contracting practice information above
Practice Name: ____
Practice Address: ____
Practice City: ________________________ Practice Zip: ______________________