We heal and inspire the human spirit.

To: IEHP Direct Providers

From: Credentialing Department

Date: January 22, 2025

Subject: **Practitioners Providing Gender-Affirming Care**

Dear IEHP Direct Provider:

To ensure compliance with Senate Bill 923, known as the Transgender, Gender Diverse or Intersex (TGI) Inclusive Care Act, IEHP would like to identify in-network providers who have affirmed they offer gender-affirming services.

For those practitioners interested in providing high quality gender-affirming services, please complete the attached survey that lists the services and provide the supporting documentation as noted in the Transgender Questionnaire.

Please provide your response to IEHP's Credentialing Department via email credentialing@iehp.org or via fax at (909) 890-5756 by Friday, January 31, 2025.

Your prompt attention is greatly appreciated.

All IEHP communications can be found at: www.providerservices.iehp.org > News and Updates > Notices

Inland Empire Health Plan

QUESTIONNAIRE FOR PROVIDERS FOR TRANSGENDER MEMBERS

IEHP would like to identify Practitioners who have experience and interest in providing high quality care to Transgender members. Please complete the following survey if you would like to be listed in our Provider Directory, as a Practitioner available to our Transgender members. **Please email completed form to credentialing@iehp.org or fax to: (909) 890-5756.**

Practitioner Name _____ License _____ NPI _____

1. Please assess your ability in providing high quality care to Transgender Members:
   ☐ No Experience ☐ Minimal ☐ Moderate ☐ Advanced
2. Approximately how many Transgender patients have you cared for in the past twelve (12) months?
   ☐ None ☐ 1 – 2 ☐ 3 – 9 ☐ 10 – 25 ☐ Over 26
3. How long have you been providing care to Transgender patients?
   ☐ Under 1 year ☐ 1 – 5 years ☐ 6 – 9 years ☐ Over 10 years
4. What training, if any, have you received to treat Transgender patients*.
   (Please provide documentation for all that apply)
   ☐ Continuing Medical Education (CME) events. ☐ Other
   ☐ Transgender Certifications through WPATH ☐ None
   ☐ Member of World Professional Association for Transgender Health (WPATH)
5. Please provide evidence of the following annual staff training on Transgender Care, that includes:
   ☐ Agenda
   ☐ Sign in Sheet
   ☐ Policies and Procedures

Please identify your skill level for the Transgender Service(s) below:

		No Experience	Minimal	Moderate	Advanced
1.	Feminizing Mammoplasty	☐	☐	☐	☐
2.	Male Chest Reconstruction	☐	☐	☐	☐
3.	Mastectomy	☐	☐	☐	☐
4.	Gender-Confirming Facial Surgery	☐	☐	☐	☐
5.	Hysterectomy	☐	☐	☐	☐
6.	Oophorectomy	☐	☐	☐	☐
7.	Penectomy	☐	☐	☐	☐
8.	Orchiectomy	☐	☐	☐	☐
9.	Feminizing Genitoplasty	☐	☐	☐	☐
10.	Metoidioplasty	☐	☐	☐	☐
11.	Phalloplasty	☐	☐	☐	☐
12.	Scrotoplasty	☐	☐	☐	☐
13.	Voice Masculinization or Feminization	☐	☐	☐	☐
14.	Hormone Therapy Related to Gender Dysphoria or Intersex Conditions	☐	☐	☐	☐
15.	Gender-affirming gynecological care	☐	☐	☐	☐
16.	Voice Therapy Related to Gender Dysphoria or Intersex conditions	☐	☐	☐	☐

*All received documents will be matched for criteria according to our policy. Outreach to the Provider will be made regarding a final decision or a request for additional documentation, if required.

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Please identify your skill level for the Transgender Service(s) below:

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