A Public Entity
Inland Empire Health Plan

Vision Network Participation Request Form

Application Instructions to Physicians/Licensed Health Care Professionals:

- Please note that completion of this form and/or credentialing application does not guarantee acceptance in the IEHP Direct Provider Network.
- Your IEHP Network Participation Form will be reviewed and a response will normally be mailed within two weeks.
- 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.

Adding a Physician/Provider to an Existing IEHP Direct Contract:
If you are a group practice that is currently contracted with IEHP Direct, and you are seeking to add a physician/Provider to your existing contract, please check the following box and provide the requested information regarding the individual Provider as requested below.

☐ **We are a practice group that is currently contracted with IEHP Direct and are seeking to add the following Physician/Provider to our existing group agreement.**

Physician/Provider Information			
First Name	**MI**	**Last Name**	**Suffix**
Street Address			**Suite**
City	**State**	**Zip Code**	
Telephone #		**Fax #**	
Tax ID #	**NPI #**		**License #**
Date of Birth / /	**Applying As** ☐ **Full Service**	☐ **Exam Only**	
Medical Group Name		**Medical Specialties**	
☐ **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. (Please attach roster)**			
Person to contact regarding this request			
Contact Phone #	**Contact E-mail Address**		

PLEASE RETURN THIS FORM AND A W-9 TO: contract@iehp.org