HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

Provider Contract Questionnaire

Instructions

- Fill out all applicable questions below, entering N/A if a question does not apply.
- Include a new W-9 if this is your initial *Provider Contract Questionnaire* or if you have had changes since your last submission.
- Fax completed forms to **1-844-836-5818**.

Section A: Provider Information

Date completed (MM/DD/YYYY):

Enter provider details.

1. **W-9 Legal Entity Name or Business Name/DBA** (If applicable):	
2. **What is the status of your W-9 submission? If "No Changes," skip to Section B.**	Initial ○ Updated ○ No Changes ○
3. **Tax Identification Number (TIN) (Required if selected Initial or Updated for #2):** • If more than one TIN is associated with the information in this section, please enter all applicable W9s with the completed *Provider Contract Questionnaire*. • If provider information differs by TIN, please complete a *Provider Contract Questionnaire* for each TIN and include a W9 with each completed form.	
4. **Total TIN Count for Associated TINs (Required if selected Initial or Updated for #2):**	
5. **Practitioner Count (Total number of Practitioners):**	
6. **Provider Website:**	
7. **Business Phone Number (Required if selected Initial or Updated for #2):**	

8. **Business Address (Required if selected Initial or Updated for #2):**

Street Address: Suite/Unit Number:

City: State: ZIP Code:

9. **Health Information Exchange (HIE) Participation Status (Required if selected Initial or Updated for #2):**	Participating: ○ Not Participating: ○
Provider Electronic Address (HISP) (Required if selected Initial or Updated for #2): • If you selected "Participating," enter your Provider Electronic Address. • If you selected "Not Participating," enter N/A.	

10. **Organization Description:**

Clinically Integrated Network (CIN):	☐	Provider Group (with more than 50 practitioners):	☐
Independent Practice Association (IPA):	☐	Solo Practitioner:	☐
Management Service Organization (MSO):	☐	Virtual Only (Telemedicine):	☐
Physician-Hospital Organization (PHO):	☐	Other: (Enter other below):	☐
Provider Group (with fewer than 50 practitioners):	☐		

11. Vendor supplier or facility?	Yes ○ No ○ N/A ○

Important: Vendor suppliers and facilities proceed to Section C.

Section B – Provider Credentialing Questionnaire

HNFS uses this section to determine delegation opportunities. Important: Section B does not apply to vendor suppliers and facilities.

Answer provider credentialing-specific questions.		Yes	No	N/A
1.	Have there been any changes since your last submission? **Important:** If "NO" skip to **Section C**.	○	○	○
2.	Does the provider credential all provider degrees and specialties?	○	○	○
	If "No," does the provider use **CAQH* Provider Data Portal** to submit universal credentialing applications?	○	○	○
3.	Does the provider agree to submit provider additions, changes and terminations using the **HNFS' roster template***?	○	○	○
4.	Does the provider agree to submit comprehensive (full) rosters at least semi-annually?	○	○	○
5.	Is the provider submitting a full roster on **HNFS' roster template*** with this request?	○	○	○
6.	Does the provider use **CAQH Provider Data Portal** to submit rosters?	○	○	○
7.	For providers in Minnesota: Does the provider use the **Minnesota Credentialing Collaborative***?	○	○	○

****Refer to "More Information" in **Section C**.*

Section C – Additional Points of Contact

Provider contract questionnaire submission status.	Yes	No	N/A
1. Are there any changes since your last submission? If "NO" proceed to **Section D**.	○	○	○

All fields are required. If the point of contact (POC) listed in "Reason for Contact" is the POC for multiple areas, please list details in each area. If "Reason for Contact" does not apply to the provider, enter N/A.

Enter applicable contact information. All required fields must be filled.

Reason for Contact	POC First/Last Name	Email	Phone	Fax
2. Case Management:				
3. Claims/Billing/ Payment Information:				
4. Credentialing (Required field if selected No for #1):				
5. HNFS Education and Newsletters:				
6. Provider Contract				
7. Provider Legal POC* (Required field if selected No for #1)				
8. Provider Directory and Rosters				
9. Referrals and Authorizations				
10. Utilization Management				

**All communication about changes impacting your provider participation agreement will be directed to the Provider Legal POC.*

More Information

CAQH – https://www.caqh.org

CAQH ProView Provider Portal – https://proview.caqh.org

HNFS TRICARE roster template –

https://www.tricare-west.com/content/hnfs/home/tw/prov/res/provider_forms/join_our_network/group-roster-template.html

Minnesota Credentialing Collaborative – https://www.mncred.org

Section D – Contact Information of Person Completing Form

Name of Person Completing Form	Title	Email	Phone