Health Net®
COMMUNITY SOLUTIONS

CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it within 48 hours via email to HN_Provider_Relations@healthnet.com, or send it via fax to 1-855-863-5987.

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received the new provider training materials from Health Net Community Solutions, Inc. (Health Net), reviewed them for training purposes, and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed Health Net's new provider training online on the provider website and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to Health Net's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and Health Net. I understand how to access and find information on Health Net's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals located under *Working with Health Net > Contractual > Provider Library.*

Provider name (PRINT)	Provider signature	Date

Provider address (street, city, ZIP)

Phone number	Email address	Tax identification number (TIN)

INTERNAL USE ONLY

Received date	Data entry date	Provider representative

Health Net®

Provider Training Sign-In Sheet

Trainer Name: _____

DATE: _____

TYPE OF TRAINING:

	New Provider Onboarding		PM160 Online Submission		Tool Kit:
	S.B.I.R.T.		Newborn Referral Process		Other:

PLEASE FILL OUT PROVIDER /CLINIC INFORMATION BELOW **- OR-** **STAMP CLINIC INFO HERE**

PROVIDER/CLINIC NAME: _____

PROVIDER NPI: _____

PROVIDER ADDRESS: _____

CITY: _____ **ZIP:** _____

PROVIDER TEL: _____ **FAX:** _____

ATTENDEES

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
1.					
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-ATTENDEES CONTINUED-

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
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