New Delegation Request

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

TRICARE®

Date Form Completed by Credentialing Point of Contact: _____

Form Instructions

1. Fill out page one of the New Delegation Request form, and save the form to your desktop.
2a. Include this completed form as an attachment in a reply to an email received from Health Net Federal Services.
2b. If you downloaded this form from the website, complete this form and add as an attachment in an email sent to your assigned Provider Network Manager.
3. Please attach a list of the active Tax Identification Numbers included in your TRICARE Preferred Provider Network Agreement. (This list should only include Tax Identification Numbers covered under your TRICARE Preferred Provider Network Agreement).

Group Information

Fill out group details in this section.

Group Name:	
Practitioner Count: (Total number of practitioners in group)	
Credentialing Point-of-Contact Name: (Person authorized to sign delegation agreement)	
Credentialing Point-of-Contact Phone: (Credentialing point of contact's direct phone number)	
Credentialing Point-of-Contact Email: (Credentialing point of contact's direct email)	
Organization Description:	
Vendor Supplier or Facility? (Y/N):	Yes No

Credentialing Questionnaire

Answer credentialing-specific questions in this section.	Yes	No	N/A
1. **Does group credential all practitioner degrees and specialties?**			
2. **Regardless of admitting privileges, are all practitioners in the group credentialed?** (If group does not credential some specialties covered by TRICARE, HNFS will need to credential these specialties.)			
3. **Group agrees to submit incremental requests following HNFS' guidelines?**			
4. **Does group agree to submit quarterly rosters following HNFS' roster submission guidelines?**			
5. **Group is submitting a full roster with this request?**			
6. **Group agrees to comply with HNFS' location limitation policy?** (Groups with multiple locations are limited to five locations in Network Provider Directory.)			
7. **If group is not submitting a full roster following HNFS' roster submission guidelines has group provided a data dictionary?** (A provider data dictionary is required to map group data when a roster following HNFS' guidelines has not been submitted.)			
8. **Group is submitting a data dictionary with this request?**			

Do not fill out this page. Internal use only below this line.

Provider Network Manager Review

Contract Type: (Must match what is documented in Mercury)	
Anchor Tax Identification Number (TIN):	
Document Control Number (DCN): (Must match base agreement or executed DCN in Mercury)	
Reason for Delegation:	
Provider Network Manager Comment: (To be completed by Provider Network Manager submitting request)	

Delegated Auditor Review

Delegation Status:	
Roster Audit Results:	Pass Fail
Roster Audit Findings: (Based on data accuracy / Choose as many as apply.)	**Not in HNFS Format** **Data Discrepancy** **Data Accuracy Below 95%**
Delegated Auditor Comment:	
Auditor Assigned: (If applicable)	