

## Partnership HealthPlan of California

### Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form and Contracted Provider Addendum

Note: This application does not substitute for the usual provider contracting/credentialing processes. All providers must complete the usual Partnership provider contracting/enrollment/credentialing processes prior to, or concurrent with, the completion of this application.

Check one:

\_\_\_ Initial (New Perinatal Case Management Service Program)

\_\_\_ Ongoing (long-standing Perinatal Case Management services, but first time completing this form)

\_\_\_ Change (Prior completion of this form; this is an update)

Date form completed: \_\_\_\_\_

Date effective (if services were provided prior to form completion, may be up to 9 months prior): \_\_\_\_\_

**Core Organizational Information:** All PHPS providers must be enrolled in the Medi-Cal Program and have an organizational NPI number

Name of Organization: \_\_\_\_\_

Organizational NPI Number: \_\_\_\_\_

Organizational Medi-Cal ID Number: \_\_\_\_\_

Mailing Address of Organization Headquarters: \_\_\_\_\_

County where Organizational Headquarters is located: \_\_\_\_\_

Counties primarily served by PHPS program: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email of Contact Person: \_\_\_\_\_

Name of CEO or signing authority: \_\_\_\_\_

Email of CEO or signing authority: \_\_\_\_\_

Name of Clinical Director of PHPS program: \_\_\_\_\_

Circle one: OB/GYN    Family Physician    Pediatrician    Certified Nurse Midwife    Licensed Midwife  
Nurse Practitioner    Physician Assistant- certified

Email of Clinical Director: \_\_\_\_\_

NPI of Clinical Director: \_\_\_\_\_

Administrative Director of PHPS program: \_\_\_\_\_

Email of Administrative Director: \_\_\_\_\_

Primary phone number for program: \_\_\_\_\_

**Type of Perinatal Services:**

- \_\_\_\_\_ Organization has at least one site that is certified by CDPH as a CPSP program  
(attach letter of approval)
- \_\_\_\_\_ Organization is not currently CPSP-certified, but has applied for this certification  
(attach a copy of the application cover page)
- \_\_\_\_\_ Organization is not currently certified, nor planning to obtain CPSP-certification status

**List ALL sites in your organization that may offer and bill for any  
Perinatal Case Management or support services:**

Site number	Name of site	Complete Address of Site
1		
2		
3		
4		
5		
6		

(Add more rows if needed)

**Identify the Perinatal Services Provider at any site in your organization:**

Service	Check if Provided in-person	Check If Provided virtually	If service is not provided in your organization or is shared with another organization, indicate partner organization(s) who will provide this service (If known/ finalized)	Indicate Capacity to accept outside referrals for this service. <b>Choose one:</b> <ul style="list-style-type: none"> <li>• No outside referrals</li> <li>• Limited outside referrals</li> <li>• None currently but planning capacity for outside referrals</li> <li>• Currently open to all outside referrals</li> </ul>
Pre-natal care (Physician/NP/PA or midwife)				
Perinatal Case Management				
Nutrition Services				
Mental Health/ Behavioral health services				
Health Education Services				
Diabetes in Pregnancy Diabetes Education				
Diabetes in Pregnancy Nutrition Education				
Diabetes in Pregnancy: Insulin/Medication titration/adjustment				
Lactation Counseling or Consultation				

**Attachments:**

- Please attach a list of staff providing these services, with their names, job titles and licensure/credentials. Please include any support staff.

Role	Total FTE	Professional Training RD/CDE/RN/LVN/MPH/MSW, ASW, LCSW, MD (OB/Gyn, Family Med) NP/PA-c CNM/LM	Number of staff in each provider type and training	License/Certification Numbers or equivalent (or send an Employment Roster with the information)
Perinatal Case Manager				
Nutrition				
Mental /Behavioral Health				
Medical Providers				
Support Staff				

- If your organization performs perinatal case management, please include a copy of the standard assessment that you use or plan to use.
- All Licensed staff must be credentialed with Partnership or with a Partnership delegate, if applicable, by July 2026

The Clinical Director's signature below attests that the Perinatal Services staff meet the required background and training to complete their tasks as outlined in policy MCUG3118 *Prenatal & Perinatal Care* for each participating staff member.

\_\_\_\_\_  
Clinical Director's Name and Signature

Submit to: [PHPS@partnershiphp.org](mailto:PHPS@partnershiphp.org)

For internal use:

Date Perinatal Site Review Last Completed: \_\_\_\_\_

Date Perinatal Site Review Passed: \_\_\_\_\_

Date Parent Organization Contract Executed: \_\_\_\_\_

Parent Organization Provider Number: \_\_\_\_\_

Other Notes: