Health Plan of San Joaquin

Mountain Valley Health Plan

Provider Directory Attestation

I attest I have reviewed my, or my Provider Group's, information on Health Plan's Provider Directory for accuracy and attest the information is correct and accurate*.

** If any updates need to be made, do not use this form. Download and make changes using the Roster Template, which includes its own attestation.*

Email completed form to: **providernetworks.verification@hpsj.com**

Name of person completing form:
Date:
Title:
Phone Number:
Email:

Provider Name:

Group, Hospital, Facility, Clinic,

ECM/CS Name:

Provider Tax ID:

Group Tax ID:

Provider NPI:

Group NPI:

Practice Address:

City:

State:

Zip Code:

Provider/Group Web Address:

FOR SKILLED NURSING/LONG TERM CARE FACILITIES ONLY:

Medical Director Name:
Phone Number:
Email: