SCCIPA
Santa Clara County IPA

Letter of Interest Form

FAX completed form and CV to 650-358-5706

or email to providersrv@ppmsi.com

***Full Name** (as it appears on your medical license): **Degree**: **License #:**	**CAQH #** (Profile must be current, and SCCIPA must be granted access to view):	**Years in Practice**: _____ ☐ **Male** ☐ **Female**
Primary Office Address:	**Phone:** **Fax:**	**Office Hours:** **Evenings or Weekends:**
Secondary Office Address:	**Phone:** **Fax:**	**Office Hours:** **Evenings or Weekends:**
Board Certified? (Must be recognized by the ABMS) ☐ YES (List Board): _____ ☐ NO, Exam Date: _____ ☐ Board Eligible, exam date: _____ ☐ Does Not Apply (certificate only)	***On Call Coverage:** Provider Name: _____ Phone #: _____	☐ Primary Care Physician: _____ ☐ Specialist: _____ ☐ Other: _____

Applying as: ☐ SOLO ☐ GROUP	**Individual NPI:** _____ **Organizational NPI:** _____	**Practice Name:** _____ **Tax ID:** _____
Additional Office Address:		**Medicare Participation Status:** ☐ YES ☐ NO ☐ IN PROCESS (Date submitted):_____
Hospital Admitting Privileges: ☐ YES, OCH____ REG____ GSAM____ ECH ____ ☐ NO ☐ Other ☐ Not Applicable		**Ambulatory Surgery Admitting Privileges:** ☐ YES (List): _____ ☐ NO
If you are a PCP, would you consider being exclusive with SCCIPA? ☐ Yes Not at this time ☐		**Other Medical Group Affiliations** (please list):

I am interested in becoming a member of SCCIPA. Please accept this as my Letter of Interest.

Signature: _____ **Date:** _____ **Phone:** _____

Provider's Personal Email (Required): _____ **Practice Email:** _____

Credentialing Email: _____ **Office Manager Name:** _____

Required Peer Reference #1 : _____**Phone:** _____

Required Peer Reference #2: _____**Phone:** _____

Required Attachments: **Curriculum Vitae**

For Office Use: Receipt Date _____