SCCIPA
Santa Clara County IPA

Thank you for your interest in becoming a participating provider with Santa Clara County IPA (SCCIPA). You must be Board Eligible or Certified in the specialty you are requesting privileges to be eligible for membership. To move forward in the credentialing process, the SCCIPA Credentialing Committee will need to review the following items:

- **Curriculum Vitae (CV/Resume)**
  - A current Curriculum Vitae is required with a minimum of the last 5 years of work history and/or training.

- **CAQH APPLICATION**
  - You must grant SCCIPA access to view by logging into your CAQH portal account.
  - Profile and supporting documents must be current in CAQH.
  - CAQH is free to providers

- **Letter of Interest Form (LOI)**
  - It is preferred that your references come from SCCIPA participating providers and that at least one of your references is a provider in your same specialty.
  - **Board Certified**
    - Must be recognized by the American Board of Medical Specialties (abms.org)
  - **On Call Coverage**
    - Cannot be self

Complete, current information on the CV, CAQH, and LOI will greatly expedite the process.

The Letter of Interest Form and your CV will be presented to the SCCIPA Credentialing Committee. If approved, you will receive the onboarding packet from your assigned representator including a copy of your contract.

Credentialing@ppmsi.com
(650) 358-5807 fax

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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 _____