



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. (optional)
 - **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 be notified that Symplr (CVO) will be reaching out to start the credentialing process. **It is imperative that the credentialing email is current on the LOI.** Once Symplr finalizes verifications, the application will be return to SCCIPA for final approval. If approved, your assigned representor will be reaching out with the onboarding packet along with a copy of your contract.

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

*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: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Primary Office Address/start date: _____		Phone: _____	Office Hours: Evenings or Weekends: _____
Secondary Office Address/start date: _____		Phone: _____	Office Hours: Evenings or Weekends: _____
Board Certified? (Must be recognized by the ABMS) <input type="checkbox"/> YES (List Board): _____ <input type="checkbox"/> NO, Exam Date: _____ <input type="checkbox"/> Board Eligible, exam date: _____ <input type="checkbox"/> Does Not Apply (certificate only)		*On Call Coverage: Provider Name: _____ Phone #: _____	<input type="checkbox"/> Primary Care Physician: _____ <input type="checkbox"/> Specialist: _____ <input type="checkbox"/> Other(Telehealth, Hospitalist, SNF) _____
Applying as: <input type="checkbox"/> SOLO <input type="checkbox"/> GROUP	Individual NPI: _____ Organizational NPI: _____	Practice Name: _____ Tax ID: _____	
Additional Office Address: _____		Medicare Participation Status: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IN PROCESS (Date submitted): _____	
Hospital Admitting Privileges: <input type="checkbox"/> YES, OCH ___ REG ___ GSAM ___ ECH ___ <input type="checkbox"/> NO <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable		Ambulatory Surgery Admitting Privileges: <input type="checkbox"/> YES (List): _____ <input type="checkbox"/> NO	
If you are a PCP, would you consider being exclusive with SCCIPA? <input type="checkbox"/> 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			