Letter of Interest
Group and Provider Information Submission Form

CommunityCare IPA

Date of Submission: _____

Complete the following group and provider information to review your request. In addition, please include copies of the following documents:

1. Letter of Interest *(if applicable, include description of specialized services and/or subspecialties)*
2. Curriculum Vitae (CV) for each provider in your group
3. Current W-9 form (*must use March 2024 version*)
4. Current Malpractice Coverage
5. California State Medical License
6. Provider roster if multiple providers in group *(Roster to include Provider name, degree, specialty, Individual NPI, license number, CAQH number, practice location(s) and all hospital and Ambulatory Surgery Center privileges for each provider)*

Complete submissions can be sent to LOI@medpointmanagement.com. Please note, incomplete or missing information will delay the review of your submission. Once all information and documents are received, please allow up to 90 days for your request to be reviewed.

Group/Provider practice includes the following specialty category(ies). Please mark accordingly:

☐ **Primary Care** ☐ **Specialty(ies)** ☐ **Hospital-Based**

<u>Group Information</u>:

Group Name:	
Tax Identification Number (TIN):	
Organization NPI:	
Contract Contact Name & Title:	
Contract Contact Email:	
Contract Contact Telephone:	
Credentialing Contact Name:	
Credentialing Contact Title:	
Credentialing Contact Email:	
Credentialing Contact Telephone:	

Provider Information *(if multiple providers, attach a provider roster)*:

Provider Name:	
Provider NPI:	
CAQH ID Number:	
Medi-Cal Certified by PAVE:	
Specialty(ies):	
Specialty(ies) Area of Expertise:	
Hospital Privileges:	
Ambulatory Surgery Center Privileges *including Dialysis Facility(ies) and Endoscopy Surgery Center(s) – if applicable*:	
I own a Dialysis Facility(ies) – if yes, please list the name of the Dialysis Facility(ies) – *if applicable*:	
I own an Endoscopy Facility(ies) – if yes, please list the name of the Endoscopy Facility(ies) – *if applicable*:	

Practice Location *(if multiple locations, please attach a practice location roster)*:

Practice Location NPI:	
Street Address, Including Suite No.:	
City, State, and Zip Code:	
Email:	
Phone:	
Fax:	
Office Hours:	
Languages Spoken:	
Ages Served:	