

St. Vincent IPA Medical Group Provider Interest Questionnaire

Thank you for your interest in St. Vincent IPA Medical Group. In order to streamline and simplify our contracting process, please take a moment to complete the below questionnaire so that we may evaluate your practice.

- What type of contract are you seeking to obtain? Individual or Group?

- What is the Practice name ? _____
- Please list all providers you are wanting to be included under this agreement along with the provider's specialty and where the provider has Hospital Privileges—

Provider Name	Provider type or Specialty	Hospital/Surgery Center Privileges

- Please list all practice addresses you would like to be included under this agreement –

In addition to this completed form, please fax or email a Letter of Interest, Curriculum Vitae (for each provider that you would like under agreement), and W-9 to (562) 207-6558 or prsvipa@pdtrust.com