ST. VINCENT IPA
The Patient's Choice for Health Care

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 in this agreement along with the providers specialty and where the provider hospital privileges

Individual Providers

Provider Name	Provider Type/ Specialty	Provider DOB	Provider SSN (not TIN)	Type 1 NPI	License Number	Hospital/ Surgery Center Privileges

Provider Groups (Payee Groups) or Organizational Providers

Group Name or Provider Name	Group or Provider Type 2 NPI	Group or Provider TIN

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

Address 1:_____

Address 2:_____

Address 3: _____

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