AFFINITY
MEDICAL GROUP

Letter of Intent Guidelines

The following questions are intended to be used as a guide, but all of the information below must be included in your submitted Letter of Intent. Please do not return this sheet as it is for your informational purposes only. Incomplete Letters of Intent will be returned.

1. **Full Name, Degree, SSN, Gender, DOB, License #, City and State of Birth, Email address of Provider applying for Membership, Practicing Specialty** *(This information is a membership requirement)*

2. **Specialty** *(Are you requesting to be considered as a PCP, Specialist, or both? If Specialist, what is your specialty?)*

3. **Board Certification** *(Are you board certified in the specialty for which you applying? If not, what is the date you are scheduled to take the boards?)*

4. **Solo or Group Practice** *(If in group practice, who are the other physicians in your group? Does your group practice under the same Tax ID Number?)*

5. **Completed W9** *(Please include a signed and dated form)*

6. **Other Group Affiliations** *(Do you belong to other IPAs or Medical Groups?)*

7. **Hospital Admitting Privileges** *(Name of Hospital or ASC where you have Admitting Privileges)*

8. **Curriculum Vitae** *(Please include a current CV)*

Affinity Medical Group
Membership Request Form

☐ **Primary Care** ☐ **Specialty Care**

Provider Information

Full Name: _____ Degree: _____

SSN: _____ Gender: _____ DOB: _____ License #: _____

City and State of Birth: _____

Practicing Specialty: _____

Provider Email Address: _____

Have you previously applied for membership with Affinity Medical Group?

☐ Yes ☐ No If yes, please provide date: _____

Board Certifications

Primary Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____ Intent Certification Date: _____

Sub-Specialty Board Certification: _____ Expiration Date: _____

If Board eligible, when did you complete your residency or fellowship?

Date: _____ Intent Certification Date: _____

Do you use an EMR? ☐ No ☐ Yes (*If Yes, which Electronic Medical Record system is used at your facility?)*

_____

Practice Information

☐ **Solo Practice** ☐ **Group Practice**
(Please provide a participating provider roster)

Group: _____ Provider Name: _____

Primary Office Address: _____

Office Phone: _____ Office Fax: _____

Affinity Medical Group
Membership Request Form

Please indicate the percentage of time spent by the requesting Provider at the primary office location: ☐ **80%** ☐ **90%** ☐ **100%**

Tax ID: _____ Languages: _____

Other IPA: _____

On Call Group / MD (must be an Affinity contracted provider within your same specialty): _____

Referred by an AMG contract provider? _____

Hospital and ASC Privileges *(Please list all Hospitals with whom you hold privileges)*

Facility & City: _____ Privileges: _____

Facility & City: _____ Privileges: _____

Physician Owned Distributorship (POD) *(If you are part of a POD or receive revenue from a POD, please provide details of your relationship with the said POD)*

☐ Yes ☐ No

_____

_____

_____

Name of Person Facilitating this Request: _____

Title / Position: _____ Email: _____

Phone: _____ Fax: _____

Please fax this completed form along with all supporting documents to Provider Network Operations at (650) 497-6898.

Physician Signature: _____ **Date:** _____