Letter of Intent Guidelines

Affinity Medical Group proudly serves the communities of Contra Costa County, Alameda County, and Santa Clara County. The following listing is intended to be used as a guide, but all 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. **Letter of Intent:** Formal notification expressing providers intent for membership and providing practice information about specialty and services performed.

2. **Affinity Membership Request Form:** The form must be completed in its entirety to be reviewed and processed.

3. **Curriculum vitae**: Provide a current CV that includes work history and schooling in month/year format.

4. **W-9:** Provide a copy of the vendor w-9 that includes TIN that provider will be billing under.

5. **Vendor Roster of all Providers and locations.** The roster should identify the location(s), phone, and fax that each provider will be rendering services, based on availability.

Affinity Medical Group
Membership Request Form

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

Provider Information

Full Name:_____Degree:_____ NPI#_____

SSN:_____Gender:_____ DOB:_____License #: _____

City and State of Birth: _____

Practicing Specialty: _____

If requesting provider is a midlevel, please identify supervising physician: _____

Specialized Services Performed: _____

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?)*

Primary Practice Information

☐ **Solo Practice** ☐ **Group Practice**

(Please provide a participating provider roster)

Group:_____

Clinic Contact: _____

Primary Office Address: _____

City: _____ State: _____ Zip: _____

Office Phone:_____Office Fax: _____

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Please indicate the Provider's schedule at the above location.

☐ Monday _____ ☐ Tuesday _____ ☐ Wednesday _____

☐ Thursday _____ ☐ Friday _____ ☐ Saturday_____ ☐ Sunday _____

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 facilities with whom you hold privileges)*

Facility & City:_____ Privilege Type:_____

Facility & City:_____Privilege Type: _____

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:_____