CONIFER HEALTH SOLUTIONS®

Provider Application

MedPRO Central Valley Medical Providers

Please complete the following information and return a signed copy via email to margarita.garcia@coniferhealth.com along with your **current Curriculum Vitae and W-9**. Your application will be reviewed by the IPA's Network Management Team & Board of Directors. Thank You.

Provider or Group Name				IPA you are interested in joining	MEDPRO (a.k.a CVMP)
Primary Address	Street		City, State		Zip Code	
	Phone		Fax		Email	
Second Address	Street, City,State		Zip		Contact Person	
	Phone		Fax			

NPI:	
TAX ID:	
License:	
CAQH:	
Specialty:	
Sub Specialty:	

☐ Solo Practice
☐ Group Practice

☐ PCP
☐ Ancillary
☐ Specialist

	YES	NO
Board Certified?	☐	☐
Board Eligible?	☐	☐
CHDP Certified?	☐	☐

Please list providers in group practice including PA's and NP's:

Please list any limitations, age restrictions or exclusions for your practice:

Please list your current hospital privileges below:

This will serve as notice of my interest in becoming a Network Provider. I also understand that this request is not a Contract with the IPA. *(An IPA Agreement and Credentialing Application will be forwarded to you for review pending approval from the Network Management Team and the Board of Directors*)

Provider Signature: ____________________ Date: ____________

For Internal IPA Use Only:

☐ IPA Approval	Chairman's Signature:	
☐ IPA Denial	Date	

Contract Request Date		Contract Rates:		Incident #	

Updated May 2018