EPIC
INDEPENDENT PHYSICIANS ASSOCIATION

Confidential

LETTER OF INTREST (LOI) APPLICATION FORM

Practice/Provider Name: _____

Specialty: _____

Provider/Group Information

TIN: _____

NPI: _____

Group NPI: _____

Medicare number: _____

Medicaid number: _____

CAQH Provider ID #: _____

Hospital Privileges:

Disclosure Information:

About the Practice

Practice Name/Provider (s) Name: _____

Type of Practice: _____

Specialty: _____

Board Certified: _____

Location (s): 1. _____

2. _____

Phone: _____ **Fax:** _____ **Hours of Operation:** _____

Office Manager Name: _____

Office Manager Email: _____