MEMBERSHIP APPLICATION FORM

Today's Date ________ Physician name *(as it appears on medical license)* ______________________________________

Degree *(ie—MD, DO, DPM, OD)* ___________ Specialty/Subspecialty ______________________________________

Board-certified? ❑ Yes, which board ___________________________ Date of Birth _____________________
❑ No – are you board-eligible? ❑ Yes ❑ No

Doctor NPI # ___________________ Practice Tax ID#_________________ Medical License # ______________

Doctor email address ________________________________ Doctor cell # _____________________________

Legal business name of practice or group ____

Website URL ____ # of NPI providers in practice ________

Office Manager name ________________________ Office Manager phone ____________________________

Office Manager email address ____

Primary Office Address __________________________________ Suite # _____ Phone __________________

City _________________________ State ________ Zip ______________ Fax_________________________

Secondary Office Address ________________________________ Suite # ______ Phone __________________

City __________________________ State ________ Zip ______________ Fax_________________________

Do you supervise mid-levels within the practice? ❑ Yes ❑ No
If yes, specify name(s), type(s) and NPI #(s)____

Electronic Health Record (EHR) vendor name____

Clearinghouse used for claims ____

Are you required to participate in MIPS? ❑ Yes ❑ No – if not, why? _________________________________

Most recent overall MIPS score = _______ Quality = ______ ACI = ______ Improvement Activity = ________

Would you like to serve on a SLPA physician operating committee? ❑ Yes ❑ No
If yes, specify your interest: ❑ Finance ❑ Quality ❑ Technology

Are you interested in participating in our accountable care organization, SLPA ACO? ❑ Yes ❑ No

PLEASE COMPLETE & SIGN THE REVERSE SIDE OF THIS FORM →

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I am currently credentialed at the following facilities: *[Check all that apply]*

HOSPITALS

❑ BJC hospital – specify ____

❑ Mercy hospital – specify ____

❑ SSM hospital – specify ____

❑ St Luke's Hospital

❑ Other hospital – specify ____

❑ None

Ambulatory Surgery Centers (ASCs)

❑ USPI surgery center – specify ____

❑ Amsurg surgery center – specify ____

❑ Meridian surgery center – specify ____

❑ Other surgery center – specify ____

❑ None

If not credentialed at any of the above facilities, please list any other facility where you are credentialed:

____

I attest that all of the information in this application is true and accurate.

____ ______________________

Physician Signature Date

Please send this completed form along with the signed participation agreement to Lisa Hunt:

Email: lihunt@uspi.com Fax: 314-667-3343

Mail: 10733 Sunset Office Drive-Suite 262, St Louis MO 63127

Note: Upon approval of your membership, you will be invoiced for the one-time $300 participation fee per physician.