UNMH
VAPC3/Choice Network
Letter of Interest Form

(Veterans Affairs Patient-Centered Community Care/Choice Card)
(Individual Providers or Provider Groups)

Business Name (on your W-9 Form) _____

Federal Tax ID#: _____
(Please attach a copy of your W-9 form).

1. If you are a sole proprietor provide your Individual NPI#: _____
2. If you are a Group Practice provide your Organization's NPI #: _____
    a. If you are a group please, attach a list of all group providers.
3. Practice Specialty: _____
4. Addresses (please attach list if more than one office location):
    a. Physical (office): _____
    b. Billing: _____
    c. Mailing: _____
5. Primary Phone: _____ Primary Fax: _____
6. Billing Phone: _____ Billing Fax: _____
7. Primary Contact Person & Title: _____
8. Primary Contact E-Mail: _____
9. Office Hours: _____
10. Practice Limitations (if any): _____
11. Electronic Claims Filing Capability? Yes ☐ No ☐
12. Have you ever been denied participation in a Federal or State program like Medicare or Medicaid?
    a. Yes ☐ No ☐
13. Please provider an email address for delivery preference of your **final executed contract**:
    a. Electronic Copy Email address: _____

This is a Microsoft Word Form that can be completed/saved on your computer**.**

Please return this form via email to VAPC3credentialing@salud.unm.edu.
Thank you.

Revised 08/12/2015