



### Interest Data Sheet

Today's Date:	
Provider Name:	
Specialty:	
Address (street, city, zip):	
Telephone:	
Office Contact Name:	
I am interested in:	<input type="checkbox"/> Centre for Health Care <input type="checkbox"/> Imperial County Physicians Medical Group <input type="checkbox"/> North County Health Services <input type="checkbox"/> San Diego Physicians Medical Group <input type="checkbox"/> Union Pacific IPA
Hospital Privileges:	
Board Certified:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eligible
Current medical group affiliation(s):	
Member of group or individual:	
Reason for interest/additional comments:	

*Please submit this form and a Provider Relations Representative will contact you.*

*Thank you for your interest.*

**Send your completed form to:**  
 Southern California Physicians Managed Care Services  
 Attn: Network Management  
 6760 Top Gun Street, Suite 100  
 San Diego, CA 92121  
 or fax to: **(858) 824-7118**