Scripps Health Plan Services
10790 Rancho Bernardo Road, San Diego, CA 92127
Phone: (888) 680-2273 · ProvRelContract@Scrippshealth.org

How to Become a Scripps Health Plan Services (SHPS) Provider

Thank you for your interest in becoming a provider with SHPS (Scripps Health Plan Services) in San Diego County. The decision to include providers in our network is carefully made by our Medical Director and Network Management Team, who evaluate various criteria.

These criteria encompass factors such as office location(s), provider quality data, services offered, the number of current in-network providers in a similar specialty, provider access to Scripps facilities, *Medicare participation,* geographic position by zip code, and the ability to provide timely access to the proposed services for our SHPS patient population.

To proceed with your application, we kindly request the following:

1. Letter of Interest (LOI): Please submit a brief Letter of Interest stating why you are interested in working with SHPS. This letter will help us better understand your motivations and goals for collaboration.

2. Questionnaire: Kindly complete the attached questionnaire, which will provide us with essential information about your practice and services. This will aid in our evaluation process.

Please email your completed LOI and questionnaire to Network Management at ProvRelContract@scrippshealth.org with the subject line "LOI Questionnaire - [Your Vendor Name]".

Once we receive your documentation, our team will review it thoroughly. We will then notify you of the determination and provide you with further instructions if your application is approved. If approved, we will guide you through the SHPS Credentialing and Contracting process.

Thank you for taking the time to apply to become a provider with SHPS. We value your interest and look forward to the possibility of working together to serve our community.

Should you have any questions or require further clarification, please do not hesitate to contact us. We are here to assist you throughout the application process.

Thank you,
SHPS Network Management
ProvRelContract@scrippshealth.org

Letter of Interest Questionnaire

Vendor Name with dba:			
Tax ID#:	National Provider ID (NPI)#:		
Primary Practice Address:			
Secondary Practice Address:			
Contact Name:	Title:		
Contact Phone:	Contact Email:		
Specialty Type:	Number of Providers:		
Specific Services Offered:			
San Diego County Service Area:	☐ South County	☐ Central County	☐ North County

Medicare Certification:

☐ Yes, our practice / providers are Medicare certified

☐ No, our practice / providers are not Medicare certified

Are you contracted with any health plans directly? ☐ Yes ☐ No

If yes, please list the names of the health plans below:

Affiliated Medical Group(s) if applicable:

Physical Therapy, Occupational and Speech Therapy Providers Questionnaire
(If this is not your specialty, please skip this section and proceed to the question at the bottom of this form.)

How many office locations do you have?

Please tell us which treatments your office provides.

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

How many providers do you have in each location?

Number of PT:	Number of OT:	Number of SP:

What is the age range for adults?

Do you treat pediatrics? ☐ Yes ☐ No	If yes, what is the age range?

Do you perform Autism evaluations? ☐ Yes ☐ No

Briefly explain why you are an asset to the SHPS Network. (Please do not write "see CV/Brochure", etc.)