

PRACTICING LOCATIONS

PROVIDERS WITH MORE THAN ONE ADDITIONAL LOCATION MUST USE THE EXCEL SPREADSHEET.
*DENOTES REQUIRED FIELDS

Scope of Practice* ☐ PCP ☐ OBGYN ☐ Specialist ☐ BH ☐ Hospital Based Only ☐ Other _____				
Is this your Primary Location?* ☐ Yes ☐ No		Practicing Location Name*		
Practicing Location Billing NPI*		Start Date at Location		
Address Line 1*	Address Line 2*	City*	State*	Zip Code*
Tax ID Number (TIN)*		Location Phone*		Location Fax*
Legal Business Name* (required if different than above)		Medical Group Practice Name* (required if different than above)		
Group Billing NPI* (required if different than above)		Group Taxonomy* (required if different than above)		
Effective Date in Group* (required if different than above)		Group Type* (required if different than above) ☐ PO ☐ PHO ☐ Independent Group ☐ Other		
Group Tax ID Number (TIN)* (required if different than above)		Group Name* (required if different than above)		
Direct appointments at this location?* ☐ Yes ☐ No		Appointment Phone (if different than Location Phone)		Provider Fax (if different than Location Fax)
Do you practice at this location at least 20 hours a week?* ☐ Yes ☐ No		Do you practice at a nonstandard practice location?* (residence, church, etc.) ☐ Yes ☐ No		
Accepting Patients at this Location* ☐ Accepting New ☐ Not Accepting ☐ Exiting Patients Only ☐ Covering Only		Include Location in Directory* ☐ Yes ☐ No	Gender Limitations*	
Accepts Minimum Patient Age*		Accepts Maximum Patient Age*		
Do you accept auto-assigned members?* ☐ Yes ☐ No		Do you accept CSHCS members?* ☐ Yes ☐ No		
Do you E-Prescribe?* ☐ Yes ☐ No		What counties do you serve?*		
Practice Capacity Minimum Enrollees* ☐ Yes ☐ No Minimum ☐ Maximum				
Practice Email*		Practice Website (if applicable)		



Non-English Languages Spoken at Location		Location Offers American Sign Language* ☐ Yes ☐ No ☐ N/A
Telecommunication Device for Deaf (TDD) Number		Text Telephone (TTY) Number
Offer Telehealth* ☐ Yes ☐ No ☐ N/A	Virtual Only* ☐ Yes ☐ No	Patient Center Medical Home Certified* ☐ Yes ☐ No ☐ N/A
Group Hours (if applicable) SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY After-hours Coverage ☐ ☐ ☐ ☐ ☐ ☐ ☐		
Practice Limitation (if applicable)		Primary Location Service
Access to Public Transportation* ☐ Yes ☐ No ☐ N/A		Language Line Available* ☐ Yes ☐ No ☐ N/A
Physical Accessibility ☐ Parking ☐ Exam Room ☐ Portable Lifts ☐ Restrooms ☐ Text Telephone (TTY) ☐ Office ADA Accessible ☐ Exam Table Scales ☐ Medical Equipment ☐ Grab Bars ☐ Non ADA Accessibility		
ADA Compliance* ☐ Yes ☐ No ☐ N/A		Completion of Cultural Competency* ☐ Yes ☐ No ☐ N/A
Completion of Annual FWA Training* ☐ Yes ☐ No ☐ N/A		CSHCS Attestation* ☐ Yes ☐ No ☐ N/A
Completion of the Model Of Care Training (if applicable) ☐ Yes ☐ No ☐ N/A		
Qualified Onsite Medical Interpreter Available* ☐ Yes ☐ No ☐ N/A		Call Ahead for Onsite Interpreter* ☐ Yes ☐ No ☐ N/A
Documents Available in Languages Other than English* ☐ Yes ☐ No ☐ N/A		Vaccines for Children Program Participant* ☐ Yes ☐ No ☐ N/A
Electronic Medical Records* ☐ Yes ☐ No ☐ N/A		Electronic Medical Records Software*

