

## PRACTICING LOCATIONS

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

|                                                                                                                                                                                                                                     |                 |                                                                                                                                                                                      |                     |                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------|
| Scope of Practice*<br><input type="checkbox"/> PCP <input type="checkbox"/> OBGYN <input type="checkbox"/> Specialist <input type="checkbox"/> BH <input type="checkbox"/> Hospital Based Only <input type="checkbox"/> Other _____ |                 |                                                                                                                                                                                      |                     |                                               |
| Is this your Primary Location?*<br><input type="radio"/> Yes <input type="radio"/> 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)<br><input type="checkbox"/> PO <input type="checkbox"/> PHO <input type="checkbox"/> Independent Group <input type="checkbox"/> Other |                     |                                               |
| Group Tax ID Number (TIN)* (required if different than above)                                                                                                                                                                       |                 | Group Name* (required if different than above)                                                                                                                                       |                     |                                               |
| Direct appointments at this location?*<br><input type="radio"/> Yes <input type="radio"/> 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?*<br><input type="radio"/> Yes <input type="radio"/> No                                                                                                                   |                 | Do you practice at a nonstandard practice location?* (residence, church, etc.)<br><input type="radio"/> Yes <input type="radio"/> No                                                 |                     |                                               |
| Accepting Patients at this Location*<br><input type="radio"/> Accepting New <input type="radio"/> Not Accepting<br><input type="radio"/> Exiting Patients Only <input type="radio"/> Covering Only                                  |                 | Include Location in Directory*<br><input type="radio"/> Yes <input type="radio"/> No                                                                                                 | Gender Limitations* |                                               |
| Accepts Minimum Patient Age*                                                                                                                                                                                                        |                 | Accepts Maximum Patient Age*                                                                                                                                                         |                     |                                               |
| Do you accept auto-assigned members?*<br><input type="radio"/> Yes <input type="radio"/> No                                                                                                                                         |                 | Do you accept CSHCS members?*<br><input type="radio"/> Yes <input type="radio"/> No                                                                                                  |                     |                                               |
| Do you E-Prescribe?*<br><input type="radio"/> Yes <input type="radio"/> No                                                                                                                                                          |                 | What counties do you serve?*                                                                                                                                                         |                     |                                               |
| Practice Capacity Minimum Enrollees*<br><input type="radio"/> Yes <input type="radio"/> No Minimum <input type="radio"/> Maximum                                                                                                    |                 |                                                                                                                                                                                      |                     |                                               |
| Practice Email*                                                                                                                                                                                                                     |                 | Practice Website (if applicable)                                                                                                                                                     |                     |                                               |



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

