



Provider Fact Sheet

Date:

Last Name: First Name: MI:

Degree: DOB: Sex: ☐ M ☐ F Social Security:

Group Name: Tax ID #:

Group NPI # (if applicable): Individual NPI #

Type of Provider:

- | | | |
|--|---|---|
| ☐ PCP (Primary Care Provider) | ☐ Ancillary | ☐ Behavioral Health |
| ☐ Specialist | ☐ CPW / Case Management | ☐ Psychiatrist ☐ Psychologist/PhD |
| ☐ Advanced Practice Provider | ☐ Therapy Services | ☐ PsyD ☐ LPC, LMFT, LCSW, etc.) |
| ☐ NP ☐ PA ☐ CNM | ☐ PT ☐ OT ☐ SLP ☐ ABA | |

Primary Specialty: Secondary Specialty:

Board Certified: ☐ Yes ☐ No Primary Board: Exp. Date:

Secondary Board: Exp. Date:

Primary Language: Other Language(s):

Medicare #: TPI #: Taxonomy #:

Has Provider Completed the "Cultural Competency" Online Training?: ☐ Yes ☐ No Date Completed:

Group Practice Website:

ADDRESS INFORMATION

Office Address:

Phone #: Fax #:

Office Hours:

Billing Address:

Phone #: Fax #:

IRS Address:

Phone #: Fax #:

Secondary Office Address:

Phone #: Fax #:

Office Hours:

Mailing Address:

Phone #: Fax #:

ADDITIONAL INFORMATION

Call Coverage: Phone #:

Hospital Privileges:

INSURANCE INFORMATION

Malpractice Carrier: Exp. Date:
Address: Phone #:
Amount: Aggregate:

LICENSE INFORMATION

License #: State: Exp. Date:
License #: State: Exp. Date:
DEA #: Exp. Date: DPS #: Exp. Date:

EDUCATION INFORMATION

Medical/Graduate School: Start Date: End Date:
Internship: Start Date: End Date:
Specialty:
2nd Internship: Start Date: End Date:
Specialty:
Residency: Start Date: End Date:
Specialty:
2nd Residency: Start Date: End Date:
Specialty:
Fellowship: Start Date: End Date:
Specialty:
2nd Fellowship: Start Date: End Date:
Specialty:

PROVIDER CONTACT INFORMATION

Administrative/Office Manager Contact Name:
Phone #: Email Address:
Billing Department/Manager Contact Name:
Phone #: Email Address:
Medical Records Requests Contact Name:
Phone #: Email Address:

Credentialing/Enrollment Contact Name:
Phone #: Email Address:

PROVIDER DIRECTORY INFORMATION

Panel Limitation(s):
Office Hours (if different from location-specific hours):
Accepting Patients: ☐ Yes ☐ No Age/Other Limitations:

SERVICE DELIVERY INFORMATION

Service Type	Yes	No	N/A
Telehealth Services Available	☐	☐	☐
In-Office Services Available	☐	☐	☐
In-Home Visits Available	☐	☐	☐

ACCESSIBILITY INFORMATION

Accessibility Feature	Yes	No	N/A
Adjustable Height Exam Tables Available	☐	☐	☐
Handicap/Wheelchair Accessible	☐	☐	☐
Wheelchairs Available Onsite	☐	☐	☐
Exam Rooms Accommodate Wheelchairs	☐	☐	☐
Handrails Available in Restrooms	☐	☐	☐
High-Capacity Weight Scale Available	☐	☐	☐

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

Provider/Authorized Representative Name:

Signature

Date