



PROVIDER INFORMATION FORM

____ *Durable Medical Equipment ____ *Medical Supplies *Other: _____

*If multiple locations, please complete attached sheet.

IDENTIFYING INFORMATION

Business Name: _____

Specialty: _____ Licenses: _____

Name of Business / Group Name (if different from above): _____

of locations: _____ (If more than one location, please specify locations on attached sheet.)

Contact/Title: _____ Contact Phone: (____) _____

Address: _____

Street

City

Zip

Phone: _____ Fax: _____

E-mail address: _____ Internet used for business? _____

Tax ID#: _____ Name affiliated with Tax ID#: _____

Medi-Cal#: _____ National Provider Identifier (NPI): _____

House Calls (Y/N): _____

Normal Office Hours: M _____ T _____ W _____ Th _____ F _____ Sat _____ Sun _____
(Please include specific hours of operations for each day of the week)

Malpractice Insurance: _____

Carrier

Policy #

Limits

Expiration

Additional Languages (other than English):

Spanish spoken by Provider (Y/N): _____ Staff (Y/N): _____

Other language(s) spoken by Provider: _____ Staff: _____

AFTER HOURS PROVISIONS: Calls to provider after normal business hours are handled:

By calling phone # _____ By an answering service _____

By calling pager # _____ By an answering machine _____

By a serviceperson _____ Other _____

HANDICAP ACCESS: To ensure that your site is accessible and useable by individuals with physical disabilities, please answer the following questions:

- | | Yes | No | N/A |
|--|-------|-------|-------|
| 1. Clearly marked curb or sign to designate handicap parking space near primary entrance. | _____ | _____ | _____ |
| 2. Building signs to identify all primary entrances that are accessible by physically disabled. | _____ | _____ | _____ |
| 3. Pedestrian ramps have a top and bottom landing at least the same width as the ramp. | _____ | _____ | _____ |
| 4. Handrails present on both sides of all stairways and ramps (threshold rises excluded). | _____ | _____ | _____ |
| 5. Primary entrance and passageway doors have minimum 48" clearance, open from the inside without special effort, open to minimum of 90-degrees, and have level clear floor on each side of doorway. | _____ | _____ | _____ |

SBRHA PROVIDER INFORMATION FORM—MULTIPLE LOCATION LISTING

If needed, please feel free to make copies of this form to list additional locations.

Location Name: _____

Contact Name: _____ Title: _____

Address: _____
Street City State Zip

Phone:(____) _____ Fax: _____ Email: _____

Location Name: _____

Contact Name: _____ Title: _____

Address: _____
Street City State Zip

Phone:(____) _____ Fax: _____ Email: _____

Location Name: _____

Contact Name: _____ Title: _____

Address: _____
Street City State Zip

Phone:(____) _____ Fax: _____ Email: _____

Location Name: _____

Contact Name: _____ Title: _____

Address: _____
Street City State Zip

Phone:(____) _____ Fax: _____ Email: _____

Location Name: _____

Contact Name: _____ Title: _____

Address: _____
Street City State Zip

Phone:(____) _____ Fax: _____ Email: _____



Please indicate the Durable Medical Equipment and / or Medical Supplies that you provide to members of CenCal Health. Please also indicate if these items can be picked up, delivered, or mail ordered.

Provider Name: _____

| DME/Medical Supplies | Yes, we provide these items | Pick up | Delivery | Mail Order |
|-----------------------------|------------------------------------|----------------|-----------------|-------------------|
| Apnea Monitors (adults) | | | | |
| Apnea Monitors (children) | | | | |
| Bandages | | | | |
| Bathroom Equipment | | | | |
| Breast Pumps | | | | |
| Canes / Crutches | | | | |
| CPAP / BiPAP Units | | | | |
| CPM Units | | | | |
| Creams / Washes | | | | |
| Decubitus Care | | | | |
| Diabetic Supplies | | | | |
| Enteral Supplies | | | | |
| Hospital Beds | | | | |
| Incontinence Supplies | | | | |
| Needles / Syringes | | | | |
| Nutritional Supplements | | | | |
| Ostomy Supplies | | | | |
| Oxygen / Respiratory | | | | |
| Spinal Stim | | | | |
| TENS | | | | |
| Traction / Trapeze | | | | |
| Uterine Monitors | | | | |
| Walkers | | | | |
| Wheelchairs – Manual | | | | |
| Wheelchairs – Power | | | | |
| Wheelchairs – Rental | | | | |
| Wheelchair Repairs | | | | |
| Wheelchair Seating | | | | |
| Urology Supplies | | | | |
| Other: | | | | |
| | | | | |
| | | | | |
| | | | | |