Provider Information Form

CenCal HEALTH®
Local. Quality. Healthcare.

☐ **New** ☐ **Existing/Add Changes**

HOW TO SUBMIT

Please return completed form by:

- **Fax:** 805-681-3019
- **Email:** psrgroup@cencalhealth.org

Please email the above PSR Group if you have questions when filling out this form.

SECTION 1: BUSINESS NAME AND CONTACT INFORMATION

Legal Business Name: Specialty:

NPI (Organizational): NPI (Individual):

Site Phone: Site Fax:

After-hours phone (if different): Site Email:

Website Address:

Main Practice Location Name:

Main Practice Physical Address:

Telehealth offered at this site?

☐ Both (In-Person and Telehealth) ☐ Only Telehealth ☐ No Telehealth (In-Person Only)

Languages spoken other than English:	**Lanuage Fluency Level**
Clinical Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor
Office Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Office Hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Closed/Lunch							

SECTION 2: PAYMENT/BILLING INFORMATION

Billing Contact: Direct Phone:

Billing Email: Billing Fax:

Billing Service Phone:

Pay To Address (fromW-9):

SECTION 3: PROVIDER PORTAL INFORMATION

Administrative User First/Last Name:

Administrative User Title:

Contact Phone:

Contact Email Address:

SECTION 4: CONTRACTING CONTACT INFORMATION

First/Last Name:

Phone: Email:

Signing Authority Title:

First/Last Name:

Phone: Email:

Signing Authority Title:

**For all Organizations (excluding Individuals/Sole Proprietors) submit a PDF copy of your Statement of Information (SOI) with the attached Provider Information Form. Only SOI-listed individuals may be included in Sect. 4; sole proprietors excluded. You may obtain your (SOI) by using the below link:*

Link to SOI website

SECTION 5: CREDENTIALING CONTACT INFORMATION

Credentialing Name:

Address:

City: State: Zip Code:

Credentialing Phone: Credentialing Fax:

Credentialing Email:

SECTION 6: OFFICE STAFF INFORMATION

Office Manager: Direct Phone:

Office Manager Email:

Do you use electronic medical records (EMR)?: YES NO

What is the name of the EMR system?:

Medical Records Contact:

PCP Office: *The person who submits authorizations.*

Specialists: *The person who calls the PCP to request authorizations.*

Authorization Contact: Direct Phone:

Authorization Email*:

****For authorizations, we recommend an unchanging account that does not include office staff names. For example, medicalgroup@yahoo.com.***

SECTION 7: ADDITIONAL LOCATIONS

Additional Practice #2

Additional Practice Location Name #2:

Additional Practice Physical Address #2:

NPI:

Telehealth offered at this site?

☐ Both (In-Person and Telehealth) ☐ Only Telehealth ☐ No Telehealth (In-Person Only)

Contact: Phone: Fax:

Languages spoken other than English:	**Lanuage Fluency Level**
Clinical Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor
Office Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Office Hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Closed/Lunch							

Additional Practice #3

Additional Practice Location Name #3:

Additional Practice Physical Address #3:

NPI:

Telehealth offered at this site?

☐ Both (In-Person and Telehealth) ☐ Only Telehealth ☐ No Telehealth (In-Person Only)

Contact: Phone: Fax:

Languages spoken other than English:	**Lanuage Fluency Level**
Clinical Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor
Office Staff:	☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Office Hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Closed/Lunch							

To add more additional locations, please attach CenCal Health roster.

Download CenCal Health Provider Roster Template

SECTION 8: ALL PROVIDERS RENDERING SERVICE, INCLUDING NPMP, ALLIED, ETC.

Please attach practice roster.

Provider Name 1:

NPI: Gender: Date of Birth:

Provider Degree Information:

Medical License: DEA:

☐ 40 hours/week OR hours/week

Languages (other than English):

Site Address:

Credentialing Name:

Race: Ethnicity:

Telehealth offered at this site?

☐ Both (In-Person and Telehealth) ☐ Only Telehealth ☐ No Telehealth (In-Person Only)

Provider Name 2:

NPI: Gender: Date of Birth:

Provider Degree Information:

Medical License: DEA:

☐ 40 hours/week OR hours/week

Languages (other than English):

Site Address:

Credentialing Name:

Race: Ethnicity:

Telehealth offered at this site?

☐ Both (In-Person and Telehealth) ☐ Only Telehealth ☐ No Telehealth (In-Person Only)

***To add more rendering providers, please attach CenCal Health roster** - Download Link Above.*

SECTION 9: ACCEPTING NEW PATIENTS

☐ Accepting New Patients (For PCPs and ECM Providers Only) ☐ Established Patients Only (EPO)

What is the age range you are willing to accept?: Min: Max:

SECTION 10: PRIMARY CARE PHYSICIANS ONLY

Physician/Group Name:

NPI: Effective Date:

Plan	Capacity	Access Level	Age Range
SBHI	Members	☐ Auto Assign ☐ Open Access ☐ EPO	Min: Max:
SLOHI	Members	☐ Auto Assign ☐ Open Access ☐ EPO	Min: Max:

SECTION 11: PCP AFTER HOURS (PRIMARY CARE PHYSICIANS ONLY)

CenCal Health's goal is to keep members out of the emergency department and urgent care centers for services that can be managed by Primary Care Providers (PCPs). CenCal Health offers additional reimbursement to PCPs for after-hours visits (Monday through Friday after 5 p.m. or on weekends).

For details see: http://www.cencalhealth.org/providers/search-provider-network/

How are you meeting the expectation for 24/7 coverage?

☐ Office phone rolls over to doctor's phone ☐ Answering service contacts on-call doctor

☐ Answering machine provides on-call doctor's phone number ☐ Call group ***(if checked, complete below)***

List providers with whom you have call group arrangements outside of normal office hours:

Provider Name: Provider NPI:

Provider Name: Provider NPI:

Provider Name: Provider NPI:

SECTION 12: PCP PROGRAM/SPECIALTY PARTICIPATION

Comprehensive Perinatal Services Provider (CPSP): ☐ Yes ☐ No

SECTION 13: BEHAVIORAL HEALTH ABA PROVIDERS ONLY

Appointments Available: ☐ Morning ☐ Afternoon ☐ Both

Treatment Based on/in (check all that apply): ☐ Clinic ☐ Home ☐ Community

ABA Service Areas: ☐ Santa Barbara County Cities: ☐ All or ☐ City:

☐ San Luis Obispo County Cities: ☐ All or ☐ City:

Print Name | Signature | Date

For Internal Office Use Only		
Facility Site Review Required: ☐ Yes ☐ No	Contract Required: ☐ Yes ☐ No	
PCP Short ID:	Assign PSR:	Roster Received: ☐ Yes ☐ No