Clinic Information Sheet

All fields with asterix are mandatory. Please complete this form in its entirety and use "N/A" if not applicable.*

Clinic Information		
*Group Name / Legal Name:	*Group Tax ID:	
*Clinic Site Name:		
*Clinic NPI:	*Clinic Tax ID:	*BPHC Assigned Number:
*Scope of Services:	*Designated as a 501C?: ☐Yes ☐No	
* Age Restriction ☐Yes From: _____ To: _____ ☐No	*Gender Restriction ☐Yes _____ ☐No	*Accepting New Patients? ☐Yes ☐No
*What type of clinic is this? ☐PCP ☐SPC ☐BH		
*Servicing Address:		
Address: Phone: Fax:	Applicable lines of business: ☐Medicaid ☐Marketplace ☐Duals ☐Medicare ☐CHP	Office Hours:
*Provider's Language(s) Spoken:	*DHCS Verification: ☐Yes ☐No	
*Grantee Organization Type Description:	*Please also include: • A current and updated W9 that is dated within one year • A list of providers (name and NPI) to be listed at this location	