



Group/Legal Name	
Due Date	
Return to	

Provider Information Data Sheet

Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

Section 1: Provider Information		
Group Name/ Facility Name/ Legal Name:		
Last Name:	First Name:	Middle Initial:
Provider Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Provider's Ethnicity:	Provider's NPI #
CAQH #	State License #	Highest Degree
BCBA #	Medicare Certified (if yes, CCN#) <input type="checkbox"/> Yes CCN# _____ <input type="checkbox"/> No	
All Specialties:	DEA #	Taxonomy Code(s):
Billing/Mailing Address:		Billing Phone: Billing Fax:
Billing ID / TIN#	Billing Form/Type <input type="checkbox"/> HCFA CMS-1500 <input type="checkbox"/> UB-04	Billing NPI #
Email Address for Service Location:		Public Email Address:
Primary Servicing Address: (if different from Billing) <i>(If more than one office, please attach roster of all locations (address, phone, fax and which providers go to which locations))</i>		Office Phone: Office Fax:
Office Hours: Monday: From ____ To ____ Tuesday: From ____ To ____ Wednesday: From ____ To ____ Thursday: From ____ To ____ Friday: From ____ To ____ Saturday: From ____ To ____ Sunday: From ____ To ____		
Specific Hours (If any):		
Provider's Language(s) Spoken:	Clinical Staff Language(s) Spoken:	Office Staff Language(s) spoken:
Qualified Medical Interpreter Language(s) (ICE Approved):	Current Site Review on file? (PCPS Only) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Exclusive Telehealth Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	"Physical" AND Telehealth Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Accepting New Patients-Physical? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting New Patients-Telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Age Restriction <input type="checkbox"/> Yes From: ____ To: ____ <input type="checkbox"/> No	Medical Board Certified Specialty <input type="checkbox"/> Yes #: _____ <input type="checkbox"/> No If yes, specialty: _____	
Gender Restriction <input type="checkbox"/> Yes <input type="checkbox"/> No	CCS Paneled <input type="checkbox"/> Yes <input type="checkbox"/> No	CPSP Certified <input type="checkbox"/> Yes <input type="checkbox"/> No
CHDP Certified <input type="checkbox"/> Yes <input type="checkbox"/> No	FQHC Certified <input type="checkbox"/> Yes <input type="checkbox"/> No	Community Clinics <input type="checkbox"/> Yes <input type="checkbox"/> No
Traditional Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Any provider who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan.)</i>		Is this a Primary Care Provider (PCP) <input type="checkbox"/> Yes <input type="checkbox"/> No



Group/Legal Name	
Due Date	
Return to	

Provider Information Data Sheet

Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

Section 2: For Provider's with Hospital & ASC Affiliations	
Hospital Name 1:	Hospital Admitting Privilege (s) 1 <input type="checkbox"/> Admitting <input type="checkbox"/> Consulting <input type="checkbox"/> Provisional <input type="checkbox"/> Teaching Hosp
Hospital Name 2:	Hospital Admitting Privilege (s) 2 <input type="checkbox"/> Admitting <input type="checkbox"/> Consulting <input type="checkbox"/> Provisional <input type="checkbox"/> Teaching Hosp
Ambulatory Surgical Center 1:	
Ambulatory Surgical Center 2:	
I hereby affirm that the information submitted in this Provider Data form is current, correct, and complete to the best of my knowledge and belief in good faith.	
Print Name: _____ Signature: _____ Date: _____	
Section 3: For Ancillary & Hospital Providers	
Please Mark all that applies: <input type="checkbox"/> California Children Services (CCS) <input type="checkbox"/> JCAHO <input type="checkbox"/> Teaching Hospital <input type="checkbox"/> Tertiary Hospital	
Section 3a: For Skilled Nursing Facilities	
Subacute: <input type="checkbox"/> Yes <input type="checkbox"/> No (Skilled only)	Number of Beds:
Levels of Care available at Facility:	
Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Bariatric: <input type="checkbox"/> Yes <input type="checkbox"/> No
Section 4: For Direct Primary Care Physicians making rounds at Skilled Nursing Facilities:	
Only Seeing Established Custodial Patients: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Only Seeing Established Skilled Patients: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Open to accept Established Patients that are now Custodial: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Open to accept new Custodial Patients: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(That have never been seen by or assigned to me before)</i>	
I make rounds at the following Skilled Nursing Facilities: <i>(If more than 20 please attach a separate list)</i>	
1)	11)
2)	12)
3)	13)
4)	14)
5)	15)
6)	16)
7)	17)
8)	18)
9)	19)
10)	20)
I hereby affirm that the information submitted in this Provider Data form is current, correct, and complete to the best of my knowledge and belief in good faith.	
Print Name: _____ Signature: _____ Date: _____	



Group/Legal Name	
Due Date	
Return to	

Provider Information Data Sheet

Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

Section 5: For Behavioral Health Providers Only

1.	Individual/Group Mental Health Evaluation and Treatment (Psychotherapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No	16.	Trauma and Stressor-Related Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Psychological Testing when Clinically Indicated to Evaluate a Mental Health Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	17.	Dissociative Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Comprehensive Diagnostic Evaluation for ASD (ADOS, ADI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	18.	Sexual Dysfunctions? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Psychiatric Consultation for Medication Management? <input type="checkbox"/> Yes <input type="checkbox"/> No	19.	Gender Dysphoria? <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Screening and Brief Intervention (SBI)? <input type="checkbox"/> Yes <input type="checkbox"/> No	20.	Feeding and Eating Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Neurodevelopmental Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	21.	Elimination Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	ABA Behavioral Health Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	22.	Sleep-Wake Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Neurocognitive Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	23.	Disruptive, Impulse-Control, and Conduct Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Substance-Related and Addictive Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	24.	Personality Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Schizophrenia Spectrum and Other Psychotic Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	25.	Paraphilic Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Bipolar and Related Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	26.	Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized? <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Depressive Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	27.	Bariatric Counseling Services? <input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Anxiety Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	28.	Other Areas of Expertise:
14.	Obsessive-Compulsive and Related Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	29.	Please list billing codes used most often:
15.	Somatic Symptom and Related Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Section 6: For Behavioral Health Therapy Providers Only

1.	Perform Comprehensive Diagnosis Evaluations? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Number of providers in your group/agency by QAS level QASP: _____ QASPRO: _____ QASPARA: _____
3.	Qualifications of staff
4.	Training provided to staff:
5.	Demographics/Service Area(s)



Group/Legal Name	
Due Date	
Return to	

Provider Information Data Sheet

Please fill this form out in its entirety per provider. Please put "N/A" if not applicable.

Section 6a: Experience with the following behaviors/intervention areas:

1.	Non-compliance <input type="checkbox"/> Yes <input type="checkbox"/> No	10.	Self-Help Skills <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Physical Aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	11.	Self-Direction <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Verbal Aggression <input type="checkbox"/> Yes <input type="checkbox"/> No	12.	Social Skills <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Outbursts <input type="checkbox"/> Yes <input type="checkbox"/> No	13.	Hygiene <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Property Destruction <input type="checkbox"/> Yes <input type="checkbox"/> No	14.	Toilet Training <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Self-Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	15.	Independent Living Skills <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Elopement <input type="checkbox"/> Yes <input type="checkbox"/> No	16.	Safety Awareness <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Stereotypic behavior <input type="checkbox"/> Yes <input type="checkbox"/> No	17.	Food Selectivity <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Functional Communication <input type="checkbox"/> Yes <input type="checkbox"/> No	18.	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby affirm that the information submitted in this Provider Data form is current, correct, and complete to the best of my knowledge and belief in good faith.

Print Name: _____ **Signature:** _____ **Date:** _____