AltaMed

QUALITY CARE WITHOUT EXCEPTION™

PROVIDER APPLICATION FORM

Contract Entity Name: *(Including DBA if applicable)*		FQHC	*Internal Use Only* **Client:**	AltaMed PACE Omnicare
	Tax ID:	Group NPI:		
Provider Name (Last, First Title):				
Date of Birth:		**Gender:**		
CAQH Number:				
Credentialing Contact:	***Email required**			
Group Contract Status:	Contract Established/Existing	New Contract		

CA License Number:		**CA DEA Number:**	
NPI:		**Taxonomy:**	
Primary Specialty:		**Secondary Specialty:**	
Board Certified:	Yes No (if not board certified please disclose board intentions)		
ASC Privileges:	**Please list**		
Hospital Privileges:	**Please list**		
Dialysis Center Privileges:	**Please list**		
Age Limits:	***Required**		
Languages Spoken other than English (by provider and staff)	**Please list**		
Supervising Physician (if mid-level):	***Required**		
Provider Email:	***Required**		
Special Services:	CCS CHDP CPSP HIV	**Provider Offers Telehealth:**	Yes No
EHR:	Yes No Vendor:		
Claims:	Manual Electronic Vendor:		
Other IPA Contracts:		Enrollment	Cap Rates
	1.		
	2.		
	3.		
	Comments:		
LOB:	Medi-Cal	Medi-Cal Number:	Medicare / Medicare Number:
	Commercial	PACE	Cal MediConnect

Business Office Mailing Address

Address	Phone	Fax Number	Hours

Physical Location(s) (as it will appear on directory. If same, type "Same as Above")

Address	Phone	Fax Number	Hours	After Hours Phone
Site1:				
Site2:				
Site3:				
Site 4:				