PHP, PHC California

INSTRUCTIONS:

Please submit this completed form and the required attachments to **PositiveContractingDept@ahf.org**. Incomplete forms will be returned for completion prior to processing. Please return this form and all applicable attachments.

Join Our Network Form

1. ORGANIZATIONAL INFORMATION

(Provide physical location information on the following page)

Legal Name of Organization:
(Legal name listed with the IRS)

DBA Name of Organization:
(If applicable)

Historic Name(s) of Organization:
(If applicable)

Organization Medicare Number: *(primary)*	Medicaid or Medi-Cal Number: *(primary)*
Organization TIN: *(primary)*	Organization NPI: *(primary)*

Contact

Name: _____

Email: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Practice Location Contact

Name: _____

Email: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____

State: _____ Zip: _____

2. GENERAL INFORMATION

☐ Check here if your PAVE application is pending approval *(applicable to California Providers)*

CAQH ID Number:	Fax Number:
County and State:	Website:
Primary Specialty:	
Secondary Specialty(ies):	

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

Only include information for locations that you wish to be listed.

3. PHYSICAL LOCATION INFORMATION:
(Include any additional information relevant to his location on a separate sheet)

Location DBA
(if different than the Organization DBA)

Other DBAs Previously Used
(if under same ownership)

Is this location Medicare Certified? ☐ Yes ☐ No	Is this the primary address? ☐ Yes ☐ No
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location Street Address: _____ Address Line 2: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____	State provider # *(if applicable, LTC, etc.)*: Is this location handicap accessible? ☐ Yes ☐ No How did you hear about us?

List any languages spoken by office personnel:
(including American Sign Language (ASL))

Practice Limitations *(e.g., age, gender, etc.)*:

Location State License(s) and/or State Registration(s) – *(Attach a copy of all)*

☐ *Check here if there is more than one (1) service location. If so, attach listing that captures full address, hours of operations, and practice limitations (e.g., ages, gender, etc.) for each location.*

Type of Credential	State	Number	Medicaid/Medi-Cal #	Additional Notes/Info
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials – *(Attach a copy of all)*

☐ *Check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Medicaid/Medi-Cal #	Additional Notes/Info
DEA				
CLIA				
Provider Degree Type (e.g., MD, DO, NP)				
Provider Primary Board Certification Type				

Specialty & Federal Taxonomy Code	Name of Hospital(s) where privileged *(if applicable)*

Patient Service Area(s) *(Check all that apply):*	
☐ *Check here if you are affiliated or associated with an Ambulatory Surgery Facility*	
☐ *Check here if your organization is NOT accredited and NOT required to be surveyed by ANY organization*	
Select your organization's service area by marking the box next to the counties	**Name of affiliated Hospital or Ambulatory Surgery Facility**
☐ (Statewide) National areas	
☐ (CA) Los Angeles County	
☐ (Other) Name of County:	
☐ (Other) Name of County:	
☐ (Other) Name of County:	
☐ (Other) Name of County:	
☐ (Other) Name of County:	