PCP SITE IDENTIFICATION FORM

Facility Name:		**DHCS Site ID#** (for health plan use only):	
Address:			**Site NPI:**
Site Email Address:			
IPA Name(s) for Medi-Cal Managed Care:			
Is the clinic type a Federally Qualified Health Center, Rural Health or Indian Health? ☐ **Yes** ☐ **No**			
Telephone:		**Fax:**	
Office/Business Hours:	Monday	Tuesday	Wednesday
Thursday	Friday	Saturday	Sunday
Site Contact Person:		**Contact Person Email Address:**	
Contact Person Phone #:		**Review Date:**	**Time:**

Please list ALL the Managed Care Health Plans that your members are covered under (e.g., Anthem Blue Cross, etc.):

____

____

PHYSICIAN PROVIDER INFORMATION (please list additional providers on a separate form)

Name, Title (MD, DO)	PCP and/or Specialty Type	License #	Provider NPI #	Hospital Privileges Yes	No	Hospital	Specific Days and Hours at this Site
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						
	Board Cert? ☐ **Yes** ☐ **No**						

NON-PHYSICIAN (NP, PA, CNM) PROVIDER INFORMATION (please list additional providers on a separate form)

Name, Title (NP, PA)	Specialty Type	License #	NPI #	Supervising Physician/License #	Specific Days and Hours at this Site

OTHER BACK OFFICE STAFF:
# of RNs _____ # of LVNs _____ # of MAs _____ # of Other: _____
Title(s) of Other Staff: _____

LANGUAGE CAPABILITIES: List the language(s) that the providers & staff are proficient in other than English

Provider(s) _____

Other staff _____

AGE OF POPULATION CARED FOR: AGES _____ TO _____

Percentage of population below 21 years of age: _____%

SECURITY OF MEDICAL RECORDS:

Name of the individual responsible for securing and maintaining the security of Medical Records: _____

If using Electronic Medical Records (EMR), add name of the EMR: _____

PLEASE READ CAREFULLY BEFORE SIGNING

SHARED PRACTICE ATTESTATION

The Department of Health Care Services (DHCS) All Plan Letter 22-017 defines the documentation of patient care by all Primary Care Providers (PCP) on site that occurs in universally shared medical records as a "shared" medical record practice. A shared medical record practice occurs when multiple PCPs see the same patients and use the same medical records for documentation of patient care. Shared medical records are not identified as separate records belonging to any specific PCP. Medical record review scores calculated on shared medical records apply to each PCP listed on the previous page.

Is this site a shared medical record practice? ☐ Yes ☐ No

Are there aspects of the medical record practice that is not shared by all PCPs on site (in other words, provider types/specialties, member age restrictions with certain PCPs, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)

Comments: _____

_____

The collaborating Medi-Cal Managed Care Health Plans define the mutual and routine use of site personnel, office policies & procedures, facilities, equipment and other aspects of the clinic to complete daily activities and patient care in this physical address location as a "shared" site practice. Facility site review scores calculated on a shared site practice apply to each PCP listed on the previous page.

Is this a shared site practice? ☐ Yes ☐ No

Are there aspects of the site that is not shared by all PCPs on site (in other words, equipment, exam rooms, personnel, etc.)? ☐ Yes ☐ No ☐ N/A (please comment below)

Comments: _____

_____

I hereby certify, under the penalty of perjury, that all statements made on this form are true and complete:

Provider/Designee Name (please print): _____ Job Title: _____

Signature: _____ Date: _____

FACILITY SITE REVIEW NOTIFICATION REQUEST: If Facility Site Review scores need to be forwarded to an additional person, please provide the following information:

Name/Title: _____

Name of Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

VERIFICATION BY REVIEWER:
Reviewer's Signature _____ Date:_____