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	