PRACTICE INFORMATION FORM

SECTION I: General Information

1. Name of Practice: _____

2. TIN#: _____

3. Practice Type: ❍ Single Specialty ❍ Multi-Specialty ❍ Ambulatory Surgery Center(s) ❍ Other

Please list specialties: _____

_____

_____

4. Executive Physician Lead Information:

First Name: _____ MI: Last Name: _____ Degree(s) _____

Title(s) / BoardCertification(s): _____

Phone Number: _____ E-Mail: _____

5. Practice Administrator/Office Manager Information:

First Name: _____ MI: Last Name: _____

Phone Number: _____ E-Mail: _____

6. What is your service area? _____

7. What are the key service lines your Practice(s) offer? _____

_____

_____

Attach roster of Primary Care Providers (PCPs) and Specialists providers (by specialty). Please include location(s), board certifications, NPI numbers, individual email addresses, individual cell phone numbers, and if Patient Centered Medical Home (PCMH) recognized.

NOTE: *PCPs include Internal Medicine, Family Medicine, and Pediatrics*

PRACTICE INFORMATION FORM

SECTION II: Provider Practice Profile

1. Number of providers: _____

2. Provider(s) employed by: _____

3. List facility(ies) where providers have privileges: _____

_____

4. Estimated number of patients empaneled: _____

5. Do your providers participate in any of the following programs?

Accountable Care Organization (ACO)	❍ Yes	❍ No
Bundled Payment for Care Improvement (BPCI)	❍ Yes	❍ No
Clinically Integrated Network (CIN)	❍ Yes	❍ No
Comprehensive Primary Care Initiative (CPCI)	❍ Yes	❍ No
Comprehensive Primary Care Plus (CPC+)	❍ Yes	❍ No
Medicare Shared Savings Program (MSSP)	❍ Yes	❍ No

Other (please specify): _____

_____

6. Do your providers have active co-management agreement(s)? ❍ Yes ❍ No

If yes, what specialties and with what facility(ies)? _____

_____

_____

7. Do your providers participate in any risk-based contracts? ❍ Yes ❍ No

If yes, which payer(s) and product(s)? _____

_____

8. Are your providers eligible by CMS to participate in Medicare? ❍ Yes ❍ No

9. Have any of your providers had a malpractice claim or any action (including any corrective action, adverse action, suspension, or termination) limiting their ability to practice from a payer, government entity, credentialing body (including hospital/health system), or pursuant to Medical Staff By-Laws? ❍ Yes ❍ No

If yes, please explain: _____

_____

_____

_____

10. Do your providers participate in the CMS' Quality Payment Program (QPP)? ❍ Yes ❍ No

If yes, through which of the following do you report (check one):

- ❍ Medicare Part B Claims
- ❍ Qualified Clinical Data Registry (QCDR)

  Name of Registry:_____
- ❍ Certified Electronic Health Record (EHR)
- ❍ Group Practice Reporting Option (GPRO)

11. Are all providers in the practice accepting new patients? ❍ Yes ❍ No

If no, please list the providers who have closed panels: _____

_____

_____

_____