ALCOHOL AND DRUG

Staff #: _____
(For Info Systems Use Only)

ALAMEDA COUNTY BHCS - REQUEST FOR CLINICIAN STAFF NUMBER

PLEASE FILL THIS FORM OUT ONLINE, PRINT IT, THEN FAX OR MAIL TO IS

► = MANDATORY FIELDS – These fields ***must*** be completed or this form will be rejected.

REQUEST TYPE (select one)

□ New Clinician Staff Number
□ Update Staff Number _____
□ Expire Staff Number _____

PROVIDER TYPE (select one)

□ Clinician's Gateway Clerical ONLY Number (CG)
□ Indirect Service Input ONLY - NPI# not required (IND)
□ Level III Organization Provider-Staff Number (CC3)
□ Level III FFS Provider-Staff Number (FFS)
□ BHCS County Clinician
□ CBO Provider
□ City of Berkeley Provider

►Provider/Corporate Name: _____

►Clinic Name: _____

►Contact Person: _____ ►Phone #: _____

►Staff Name: _____ ►Phone #: _____
First Middle Last

►Sex: _____ ►Ethnicity: _____

A = White B = Black C = Native American	D = Latino E = Chinese F = Vietnamese	G = Laotian H = Cambodian I = Japanese	J = Filipino K = Other Asian L = Other	M = Unknown N = Other Southeast Asian

SSN: _____ ►Birth Date: _____

►Staff # Start Date: _____ ►Staff # End Date: _____

License #: _____ License Renewal Date: _____ State of License: _____

DEA Number: _____

►Taxonomy Code: _____ ►NPI: _____

Medicare Billable (Y/N): _____ Medicare PIN: _____

Medicare Enrollment Start Date: _____ Medicare Enrollment End Date: _____

►Languages: *(Check all that apply)*

____ English	____ Spanish	____ Chinese Dialect	___ Other
____ Japanese	____ Filipino Dialect	____ Vietnamese	
____ Laotian	____ Cambodian	____ Sign Language	

►Staff Mask: *(see Staff mask instructions)*

____ CL Nurse Spec	____ Medical Records	____ Pharmacist	____ Psychiatrist
____ Educator	____ MFC Counselor	____ PhD Waivered**	____ Psychologist
____ Intern	____ Nurse	____ Physician	____ Rehab Counselor
____ LPCC	____ Nurse Pract	____ Physician Assistant	____ Social Worker
____ LPCC w/ Family	____ Occ. Therapist	____ Psych Tech	____ Unlicensed Worker

****PhD Waivered Period (Refer to Instructions) - Start Date: _____ End Date: _____**

(For Information Systems Use Only)

PR Review By: _____ Date: _____ IS Log #: _____

Class: _____ Date of Request: _____ Date Completed: _____ Completed By: _____

SEND FORM TO:

BHCS INFORMATION SYSTEMS
1900 Embarcadero Cove, 4th Floor
Oakland, CA 94606
Tel: 510-567-8181 / Fax: 510-567-8161
QIC: 28004

PLEASE ALLOW 5 BUSINESS DAYS FOR PROCESSING