



- Internal Medicine
- OBGYN
- Pediatrics
- Gynecology
- Geriatrics
- General Practice
- Family Practice
- Adolescent Medicine



Provider Level

1. Entity Organization Name _____
2. First name _____
3. Last name _____
4. Prefix _____
5. Suffix _____
6. Provider Credential (**MD**, DO, DDS, etc.) **MD**
7. Healthcare Provider Taxonomy (Specialty) _____
8. NPI _____
9. License Number _____
10. Tax ID _____
11. State of Provider License **GA**
12. Address _____
13. City Name _____
14. State Name **GA**
15. Zip Code _____
16. Telephone Number _____
17. Fax Number _____
18. Entity Type Code **Small Practice**
(Priority Setting type, **small practice**, hospital, FQHC, CHC, CAH and Rural Hospital, etc.)
19. Estimated number of annual patient visits at the entity. _____
(Estimates are acceptable if actually information isn't known)
20. Estimated number of unique patients annually seen by the program

(Estimates are acceptable if actually information isn't known)
21. Estimated percentage of patients on:
 - Medicare - _____
 - Medicaid-other state sponsored programs - _____
 - Commercial Insurance - _____
 - Uninsured - _____