

## Breast and Cervical Health Check Screening Provider Profile

**Organization Name** \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Executive Director** or **Administrative** Contact (This person is responsible for matters regarding the BCHC provider agreement, policies and procedures.)

Name & Title \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

### **Billing/Accounting**

Billing Service Name (if applicable): \_\_\_\_\_

Billing Address: \_\_\_\_\_

Contact Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

### **General Information**

Would you like to be listed on the BCHC website? Yes \_\_\_ No \_\_\_

Would you like to be listed on the 800 as a provider? Yes \_\_\_ No \_\_\_

Will you accept referrals through the YWCA ENCORE program? Yes \_\_\_ No \_\_\_

Will you accept Hot Line referrals? Yes \_\_\_ No \_\_\_

Will you accept Colposcopy referrals from other screening providers? Yes \_\_\_ No \_\_\_

Complete a Clinic Profile for each clinic site belonging to this organization.

## Screening Clinic Profile

**Clinic Name** \_\_\_\_\_

Mailing Address \_\_\_\_\_

Physical Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**BCHC Primary Contact.** The Primary Contact is responsible for coordinating BCHC service delivery at the screening clinic, including enrollment, screening services, and case management. While other staff may provide direct clinical care or be responsible for actively case managing clients, the Primary Contact is the point person for BCHC matters for this clinic.

Primary Contact Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Please list the names and credentials of the clinicians providing Breast and Cervical Health Check screening services. If more convenient, attach a printed list of these clinicians and their credentials.

Name	Credentials	
	Highest Degree	Highest License