



Due to the new requirements from all payors. Please answer the following questions below.

Provider Name: \_\_\_\_\_

Ethnicity: (Check all that apply)

- American Indian/  
Alaska Native       Native Hawaiian/Pacific  
Islander       Hispanic/Latino       Prefer not to answer
- Black or African  
American       White /Caucasian       Asian

Facility Name: \_\_\_\_\_

1. Is your provider a PCP? \_\_\_\_\_ YES \_\_\_\_\_ NO

If your provider is a specialist, what is his/her specialty? \_\_\_\_\_

2. Is there an age limit on patients seen at the practice? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, what limits? \_\_\_\_\_  
(example: 18 and under; 5 and older)

3. Has your provider completed DSNP (Dual Special Needs Plan) Training? \_\_\_\_\_ YES \_\_\_\_\_ NO

4. Has your provider completed Culture Competency Training? \_\_\_\_\_ YES \_\_\_\_\_ NO

5. Which EMR does the practice currently use? \_\_\_\_\_

6. Does the practice have the capabilities of electronic billing? \_\_\_\_\_ YES \_\_\_\_\_ NO

7. Is your provider enrolled on the PRSS portal for compliance with DMAS? \_\_\_\_\_ YES \_\_\_\_\_ NO

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return by mail or fax.

**Please be sure to have the provider complete his/her CAQH in its entirety  
to include office hours.**