



**Beacon Health Strategies
SITE INFORMATION**

*Please provide all of the following information for each location.
(Attach extra sheets if necessary)*

Provider Corporate Name: (Practice's legal name)	
Site Name:	
Site Address:	City/State/Zip:
Phone Number:	Fax Number:
Email Address:	TTY Number:
Federal Tax Identification Number: (Please attach a W-9)	Site NPI #:
Medicaid License #:	Medicare License #:
Primary Taxonomy:	DEA #:

Out Patient Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Site Contact Information

Executive Director Name/Address:	Email Address/Phone/Fax:
CMO/Senior Clinical Director Name/Address:	Email Address/Phone/Fax:
Administrator/Practice Manager Name/Address:	Email Address/Phone/Fax:
Contracting Contact Name/Address:	Email Address/Phone/Fax:
Credentialing Contact Name/Address:	Email Address/Phone/Fax:
Claims/Billing Contact Name/Address:	Email Address/Phone/Fax:
Intake Coordinator Contact Name/Address:	Email Address/Phone/Fax:
Authorization Contact Name/Address for Authorization Letters:	Email Address/Phone: Fax: (Should Authorization letters go to this fax? Yes <input type="checkbox"/> No <input type="checkbox"/>)

Practice Coverage Information

Who is the practice's provider of psychopharmacology services? (If not available within the practice, please include the name and address of the provider(s) to whom the practice refers members for psychopharmacological evaluations.)
Beacon requires 7 day, 24 hour coverage for patients. Please indicate and explain your procedure for ensuring that clients have 24 hour access to clinical and psychopharmacological services. Beeper _____ Share Call _____ Answering Service _____
Please list the clinicians (include address and phone) who cover your practice or who are part of your call/coverage schedule.

**Beacon Health Strategies
SITE-SPECIFIC ACCOMMODATIONS**

This information will be made available to members for referral purposes.

Site Name:	
Are you currently accepting new patients? Yes / No	
Next indicate the date of the next available opening for:	
Intake appointment: _____ Child _____ Adolescent _____ Adult _____ Geriatric Urgent appointment: _____ Child _____ Adolescent _____ Adult _____ Geriatric Meds Management appointment: _____ Child _____ Adolescent _____ Adult _____ Geriatric	
Accessible by Public Transportation? Yes / No	Handicapped Accessible? Yes / No

Check all that apply in the boxes below:

Physical Accessibility	Other Accessibility
<input type="checkbox"/> Adjustable height exam table	<input type="checkbox"/> Able to create/print materials that are accessible for individuals with disabilities
<input type="checkbox"/> All services available on ground level	<input type="checkbox"/> Answering service with one or more clinicians on call 24/7
<input type="checkbox"/> Building access ramp	<input type="checkbox"/> Beeper/Direct number given to members to reach clinician on-call 24/7
<input type="checkbox"/> Designated handicapped parking	<input type="checkbox"/> Can print materials that are appropriate for individuals with disabilities
<input type="checkbox"/> Elevator/Lift	<input type="checkbox"/> Can transcribe written material into Braille or have staff member read to an individual who is blind or visually impaired
<input type="checkbox"/> Home Visiting	<input type="checkbox"/> Closed captioning available (subtitles) for video or audio on website for deaf or hard of hearing users
<input type="checkbox"/> Passenger pick-up and drop-off zone	<input type="checkbox"/> CSHCN (Personal Care)
<input type="checkbox"/> Patient lifts available	<input type="checkbox"/> Display ADA compliant major access symbols
<input type="checkbox"/> Staff experienced with wheelchair transfer techniques	<input type="checkbox"/> Elevator buttons in Braille
<input type="checkbox"/> Transfer boards available	<input type="checkbox"/> Flexible appointment times, including evenings and/or weekends
<input type="checkbox"/> Walkway free of stairs and obstacles	<input type="checkbox"/> Provide interpreter services for individuals who are deaf or hard of hearing
<input type="checkbox"/> Wheelchair access to facility	<input type="checkbox"/> RC4 Assistance (Eating)
<input type="checkbox"/> Wheelchair accessible lavatory	<input type="checkbox"/> RC4 Assistance (Home Visit)
<input type="checkbox"/> Wheelchair accessible office entrance/reception area	<input type="checkbox"/> RC4 Assistance (Personal Care)
<input type="checkbox"/> Wheelchair accessible public transit routes	<input type="checkbox"/> Signs in Braille
<input type="checkbox"/> Wheelchair accessible treatment space	<input type="checkbox"/> Staff fluent in American Sign Language
	<input type="checkbox"/> Staff fluent in languages other than English
	<input type="checkbox"/> TTY/TDD (Telephone Typewriter/Telephone Device for the Deaf)
	<input type="checkbox"/> Website content developed with consideration to the needs of users with cognitive disabilities
	<input type="checkbox"/> Website is accessible to users who are vision impaired, e.g., using screen reader technology