HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE

A Division of the UCF College of Medicine

Organization Profile (Attachment 1) Form

Organization Legal Name: _____

Organization Doing Business As Name: _____

Organization Tax ID: _____ Organization NPI: _____

Organization Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Backline Number: _____

Fax Number: _____ Website: _____

Do you have an existing EHR?

◯ Yes ◯ No

Vendor:_____

Version:_____

Do you have a Practice Management System (PMS)?

◯ Yes ◯ No

Vendor: _____

Version: _____

2014 Certified?: ◯ Yes ◯ No

Is your practice keeping or replacing your EHR?

◯ Keeping ◯ Replacing

Is your practice keeping or replacing your PMS?

◯ Keeping ◯ Replacing

POC	Name	Phone Number	E-mail Address
Administrator			
Physician			
Billing			

Other Affiliations - ACO: _____

Medical Society: _____

Network: _____

Professional Associations: _____

Is your practice Patient Centered Medical Home (PCMH) Recognized? ◯ **Yes** ◯ **No**

Have you done a Billing Audit in the past year? ◯ **Yes** ◯ **No**

Practice Demographics (Estimates)

_____ Total Annual Patient Visits

_____ Total Unique Patients (Number of Active patients)

Payor Mix (Estimates - Total Must = 100%)

_____ % Medicaid

_____ % Medicare

_____ % Private Insurance

_____ % Uninsured

Practice Demographics

_____ Number of Physicians

_____ Number of Mid-levels

_____ Number of Support Staff

_____ Number of Locations / Sites

Please fill out the Additional Information Form for each location.

Primary Location Providers

Includes Physicians Assistants and Nurse Practitioners with prescriptive privileges.

Make additional copies as needed.

First name: ○ Dr. ○ Mr. ○ Ms. _____

Last Name: _____ Credentials: ○ MD ○ DO ○ NP ○ PA ○ Other _____

Phone Number: _____ Is this the providers main location? ○ Yes ○ No

Does this provider practice Primary Care at least 40% of the time in one of the disciplines listed below? ○ Yes ○ No

Specialties: Select One

Program Type: ○ Medicare ○ Medicaid ○ Not Applicable

○ Adolescent ○ General ○ Gynecology ○ OB/GYN ○ Pediatrics

○ Family ○ Geriatrics ○ Internal Medicine ☐ Other _____

Have you attested to AIU? ○ Yes ○ No Have you attested to meaningful use? ○ Yes ○ No

Individual NPI: _____ Florida Medical License Number: _____

First name: ○ Dr. ○ Mr. ○ Ms. _____

Last Name: _____ Credentials: ○ MD ○ DO ○ NP ○ PA ○ Other _____

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Additional Location Information

Please make additional copies as needed.

Location Name: _____

Location Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

_____

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