

Primary Care and Urgent Care Provider Procedures Form

Name of practitioner completing this form: _____

Partnership HealthPlan of California (Partnership) expects that Members will require the following types of services. Please check which of the following services you intend to provide as a primary care provider (PCP) or Urgent Care (UC) services provider. You should only check "Yes" if you can demonstrate training on this topic if needed. This checklist is intended to assist our evaluation during the credentialing process to ensure that providers will meet the needs of our Members.

System	Treatment/Assessment	Yes <small>(I Provide This Service)</small>	No <small>(I would Refer)</small>
Health Care Maintenance Adult	Immunizations	<input type="checkbox"/>	<input type="checkbox"/>
	Smoking Cessation	<input type="checkbox"/>	<input type="checkbox"/>
	Nutrition Assessment/BMI	<input type="checkbox"/>	<input type="checkbox"/>
	Routine Breast Exams/Mammograms	<input type="checkbox"/>	<input type="checkbox"/>
	PAP/Chlamydia Screening As Indicated	<input type="checkbox"/>	<input type="checkbox"/>
	Pregnancy Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
	Osteoporosis Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Blood Pressure Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Lipid Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Hyperlipidemia Management	<input type="checkbox"/>	<input type="checkbox"/>
	Substance Abuse Screening and Initial Counseling	<input type="checkbox"/>	<input type="checkbox"/>
	Emotional Status Assessment (Depression)	<input type="checkbox"/>	<input type="checkbox"/>
	Colon Cancer Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Communicable Disease Screening (TB)	<input type="checkbox"/>	<input type="checkbox"/>

System	Treatment/Assessment	Yes (I Provide This Service)	No (I would Refer)
Health Care Maintenance Pediatrics	Immunizations	<input type="checkbox"/>	<input type="checkbox"/>
	Nutrition Assessment/BMI Percentile	<input type="checkbox"/>	<input type="checkbox"/>
	Nutrition Counseling	<input type="checkbox"/>	<input type="checkbox"/>
	Physical Activity Counseling	<input type="checkbox"/>	<input type="checkbox"/>
	Visual Acuity/Hearing Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Dental Assessment	<input type="checkbox"/>	<input type="checkbox"/>
	Lead Screening	<input type="checkbox"/>	<input type="checkbox"/>
	Communicable Disease Screening (TB)	<input type="checkbox"/>	<input type="checkbox"/>
	Health Safety Education	<input type="checkbox"/>	<input type="checkbox"/>
OB-GYN	Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>
	Routine Gyn Care	<input type="checkbox"/>	<input type="checkbox"/>
	Contraception	<input type="checkbox"/>	<input type="checkbox"/>
EENT	Corneal Abrasion (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Conjunctivitis (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Hordeolum (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Pharyngitis/Tonsillitis (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Otitis Media/Externa	<input type="checkbox"/>	<input type="checkbox"/>

System	Treatment/Assessment	Yes (I Provide This Service)	No (I would Refer)
Respiratory	Acute and Chronic Respiratory Diseases (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Diagnosis and Treatment of Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
	Asthma Treatment including Peak Flow Monitoring	<input type="checkbox"/>	<input type="checkbox"/>
Cardio	Hypertension (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Chest Pain (Diagnostic Work-Up)	<input type="checkbox"/>	<input type="checkbox"/>
	Stable Angina (Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	EKG Interpretation	<input type="checkbox"/>	<input type="checkbox"/>
	Venous and Arterial Peripheral Vascular Disease Work-Up	<input type="checkbox"/>	<input type="checkbox"/>
Gastro	Peptic Ulcer Disease (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Reflux Disease (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Irritable Bowel Syndrome (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Acute Abdomen (Initial Evaluation)	<input type="checkbox"/>	<input type="checkbox"/>
	Hemorrhoids (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	Diabetes (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid Disease (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>

System	Treatment/Assessment	Yes <small>(I Provide This Service)</small>	No <small>(I would Refer)</small>
Neuro	Headaches/Migraines (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Seizure Disorders (Maintenance & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Derm	Diagnosis & Treatment of Common Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
	Removal of Skin Tags & Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Hemo	Anemia (Diagnosis, Work-Up & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Hemoglobinopathy (Diagnostic Work-Up)	<input type="checkbox"/>	<input type="checkbox"/>
Ortho/Rheum	Sprains	<input type="checkbox"/>	<input type="checkbox"/>
	Fractures: Non-Operative Treatment	<input type="checkbox"/>	<input type="checkbox"/>
	Tendonitis, Bursitis (Diagnosis & Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
	Musculoskeletal Disorders (Initial Diagnosis)	<input type="checkbox"/>	<input type="checkbox"/>
	Low Back Pain (Initial Evaluation)	<input type="checkbox"/>	<input type="checkbox"/>
	Chronic Low Back Pain (Management)	<input type="checkbox"/>	<input type="checkbox"/>
	Gout Management	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	Mental Health Assessment (Includes Diagnosis & Treatment of Uncomplicated Depression/Anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
	Substance Abuse Disorder: Recognition & Initial Management	<input type="checkbox"/>	<input type="checkbox"/>

System	Treatment/Assessment	Yes	No
		(I Provide This Service)	(I would Refer)
Surgery	Basic Wound Management	<input type="checkbox"/>	<input type="checkbox"/>
	Suturing of Simple Lacerations	<input type="checkbox"/>	<input type="checkbox"/>
	I & D Abscesses	<input type="checkbox"/>	<input type="checkbox"/>
Urinary	Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>
	Kidney Stones (Diagnosis & Outpatient Treatment)	<input type="checkbox"/>	<input type="checkbox"/>
Other	Initial Health Assessment	<input type="checkbox"/>	<input type="checkbox"/>
	Allergic Disorders (Rhinitis, Chronic Urticaria, Conjunctivitis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Urgent Care

Adult	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric	<input type="checkbox"/>	<input type="checkbox"/>
Early Pregnancy Bleeding/Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate the age range(s) for the members you intend to serve:

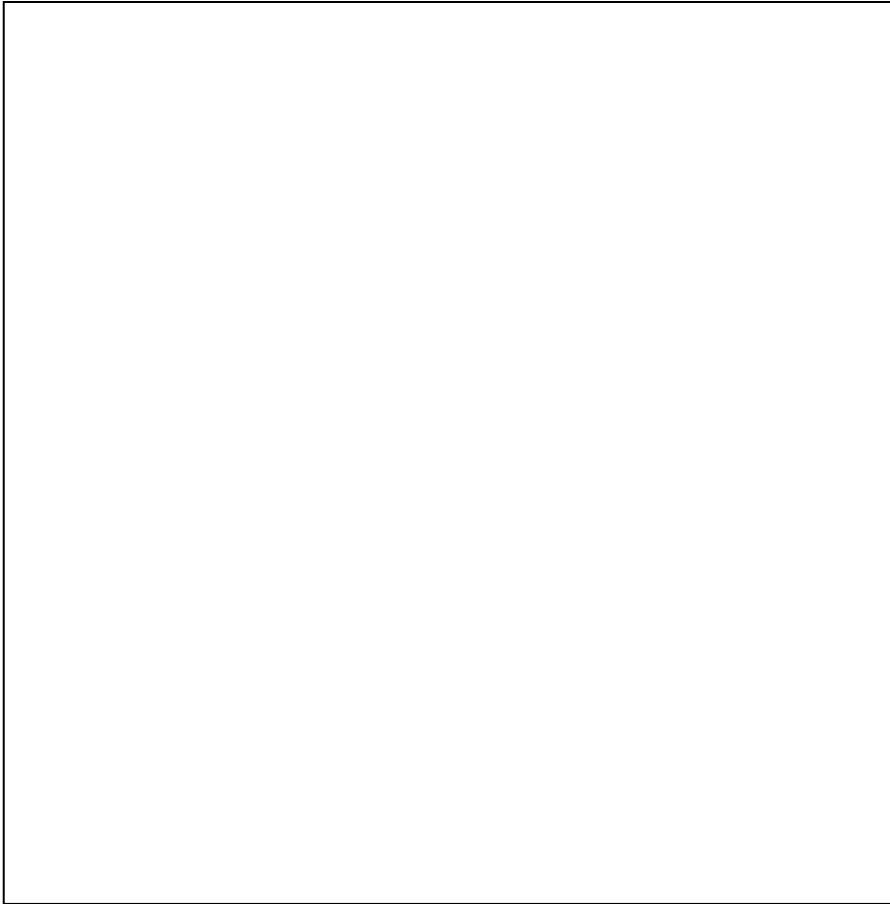
- Pediatric: 0 – 21 years old
- Children and Adults: All Ages
- Adults Only: 19 years and older
- Other Age Range: _____

Please describe any additional limitations or services on the patients you will be caring for, not listed above on the next page

Sign: _____ Date: _____
(Practitioner Signature)

Primary Care and Urgent Care Provider Procedures Form cont.

Please describe any additional limitations or services for planned procedures or age ranges in the space below. You may attach additional information, if necessary



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