Primary Care Provider Criteria Form

Partnership HealthPlan of California (PHC) 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). This checklist is intended to assist our evaluation during the credentialing process to ensure that providers will meet the needs of our members.

Name of practitioner completing this form: _____

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

System	Treatment/Assessment	Yes (I Provide This Service)	No (I would Refer)
Health Care Maintenance Pediatrics	Immunizations	☐	☐
	Nutrition Assessment/BMI Percentile/Nutritional Counseling	☐	☐
	Physical Activity Counseling	☐	☐
	Visual Acuity/Hearing Screening	☐	☐
	Dental Assessment / Topical Fluoride Varnish	☐	☐
	Blood Lead Screening	☐	☐
	Communicable Disease Screening	☐	☐
	Health Safety Education / anticipatory guidance (e.g., alcohol, tobacco)	☐	☐
OB-GYN	Prenatal Care	☐	☐
	Routine Gyn Care	☐	☐
	Contraception	☐	☐
EENT	Corneal Abrasion (Treatment)	☐	☐
	Conjunctivitis (Treatment)	☐	☐
	Sty/Stye (Treatment)	☐	☐
	Pharyngitis/Tonsillitis (Treatment)	☐	☐

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

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

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

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:	_____

Sign: _____ Date: _____/_____/_____

(Practitioner Signature)