Alaska Breast & Cervical Screening Assistance Program
Consulting Provider Profile

Organization Name:_____

Mailing Address: _____

Physical Address: _____

Phone:_____Fax:_____E-mail:_____

Executive Director or **Administrative** Contact (This person is responsible for matters regarding the AK B&C Provider Agreement, policies and procedures.)

Name & Title: _____

Phone:_____Fax:_____E-mail:_____

Billing/Accounting

Billing Service Name (if applicable):_____

Billing Address: _____

Contact Name: _____

Phone:_____Fax:_____E-mail:_____

General Information

Will you bill AK B&C secondary to primary insurance coverage? Yes ____No ___

(Laboratories only) Will you send test results to AK B&C upon request? Yes _____No ___

Complete a Clinic or Site Profile for each service site belonging to this organization.

Date this form completed ___/___/___

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Clinic Name:_____

Mailing Address:_____

Physical Address:_____

Phone:_____Fax:_____Email:_____

AK B&C Primary Contact - The Primary Contact is responsible for coordinating AK B&C service delivery at the clinic. The Primary Contact is the point person for AK B&C matters for this clinic.

Primary Contact Name:_____

Phone:_____Fax:_____E-mail:_____

Please list the names and credentials of the clinicians providing AK B&C screening services. If more convenient, attach a printed list of these clinicians and their credentials.

	Credentials	
Name	Highest Degree	Highest License

Specialties

Breast consultant? Yes ___No ___

Gynecological consultant? Yes ___No ___

Colposcopy Only? Yes ___No ___

Date this form completed ___/___/___

Profile – Other Resource/Technical Services

Site Name:_____

Mailing Address:_____

Physical Address:_____

Phone:_____Fax:_____Email:_____

AK B&C Information Contact - The Information Contact is the point person for non-billing AK B&C matters for this clinic. This may be a medical records contact.

Information Contact Name:_____

Phone:_____Fax:_____E-mail:_____

Please list the names and credentials of the clinicians providing AK B&C screening services. If more convenient, attach a printed list of these clinicians and their credentials.

	Credentials	
Name	Highest Degree	Highest License

Specialties

Mammography: Yes ___No ___
Technical component: Yes ___No ___
Professional component: Yes ___No ___

Laboratory services: Yes ___No ___

Anesthesia: Yes ___No ___

Date this form completed ___/___/___