Alaska Breast & Cervical Screening Assistance Program
Screening Provider Profile

Organization Name:_____

Mailing Address:_____

Physical Address:_____

Phone:_____ Fax:_____ E-mail:_____

Executive Director or **Administrative** Contact (This person is responsible for matters regarding 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

Would you like to be listed as a provider for women calling AK B&C directly? Yes ____ No ____

Will you accept Colposcopy referrals from other screening providers? Yes ____ No ____

Date this form completed ____/____/____

Screening Clinic Profile

Complete a Clinic Profile for each clinic belonging to this organization.

Clinic Name:_____

Mailing Address:_____

Physical Address:_____

AK B&C Primary Contact - The Primary Contact is responsible for coordinating AK B&C service delivery at the screening clinic, including enrollment, screening services, and case management. While other staff may provide direct clinical care or be responsible for actively managing clients, 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

Date this form completed ____/____/____