

# AOD

## ALAMEDA COUNTY BHCS - REQUEST FOR CLINICIAN STAFF NUMBER

PLEASE FILL THIS FORM OUT ONLINE, PRINT IT, THEN FAX OR MAIL TO IS.

- New Clinician Staff Number  
 Update Staff Number \_\_\_\_\_  
 Expire Staff Number \_\_\_\_\_

▶ Provider/Corporate Name: \_\_\_\_\_

▶ Clinic Name: \_\_\_\_\_

▶ Contact Person: \_\_\_\_\_

▶ Staff Name: \_\_\_\_\_  
*First Middle Last*

▶ Phone #: \_\_\_\_\_

▶ Phone #: \_\_\_\_\_

Staff: \_\_\_\_\_  
*(For Info Systems Use Only)*

▶ Sex:

▶ Ethnicity:

- |                     |                |                 |                           |
|---------------------|----------------|-----------------|---------------------------|
| A = White           | E = Chinese    | I = Japanese    | M = Unknown               |
| B = Black           | F = Vietnamese | J = Filipino    | N = Other Southeast Asian |
| C = Native American | G = Laotian    | K = Other Asian |                           |
| D = Latino          | H = Cambodian  | L = Other       |                           |

SSN: \_\_\_\_\_ Birth date: \_\_\_\_\_

▶ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

UPIN: \_\_\_\_\_ GL Account: \_\_\_\_\_ ▶ Taxonomy: \_\_\_\_\_

Medicare PIN: \_\_\_\_\_ DEA Number: \_\_\_\_\_ ▶ NPI: \_\_\_\_\_

Medicaid PIN: \_\_\_\_\_ Medicare Billable (Y/N):

License #: \_\_\_\_\_ Renewal Date: \_\_\_\_\_ State: \_\_\_\_\_

▶ Languages: *(Check all that apply)*

- |                                   |   |  |                                |
|-----------------------------------|---|--|--------------------------------|
| <input type="checkbox"/> English  | <input type="checkbox"/> Spanish          | <input type="checkbox"/> Chinese Dialect | <input type="checkbox"/> Other |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Filipino Dialect | <input type="checkbox"/> Vietnamese      |                                |
| <input type="checkbox"/> Laotian  | <input type="checkbox"/> Cambodian        | <input type="checkbox"/> Sign Language   |                                |

▶ Staff Mask: *(Check ONLY ONE discipline for this staff. For interns or staff in educational programs select Unlicensed Worker)*

- |  |                                       |  |  |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Educator      | <input type="checkbox"/> Intern       | <input type="checkbox"/> Medical Records     | <input type="checkbox"/> Rehab Counselor   |
| <input type="checkbox"/> MFC Counselor | <input type="checkbox"/> Nurse        | <input type="checkbox"/> Occ. Therapist      | <input type="checkbox"/> Social Worker     |
| <input type="checkbox"/> Pharmacist    | <input type="checkbox"/> Physician    | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Unlicensed Worker |
| <input type="checkbox"/> Psych Tech    | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist        |  |

*(For Information Systems Use Only)*

PR Review By: \_\_\_\_\_ Date: \_\_\_\_\_

Class: \_\_\_\_\_ Date of Request: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Completed By: \_\_\_\_\_

▶ = MANDATORY FIELDS

SEND FORM TO:

**BHCS INFORMATION SYSTEMS**

1900 Embarcadero Cove, 4th Floor  
Oakland, CA 94606

Tel: 510-567-8181 Fax: 510-567-8161

QIC: 28004

**PLEASE ALLOW 5 BUSINESS  
DAYS FOR PROCESSING**