



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Public Health Department – Administrative Services
Finance-Contracts and Grant Claiming

**SB 12 PHYSICIAN REIMBURSEMENT PROGRAM
PROVIDER ENROLLMENT**

(Please print or type)

Full legal name of entity

DBA to be used for SB 12 billing

Type of Entity: Individual Sole Proprietor Partnership Medical Corporation

Tax ID Number (TIN) _____ SSN EIN

Composition of ownership. This is a Mandatory Section. Please check all that apply:

- | | | | | | |
|-----|--------------------------|--|-----|--------------------------|---------------------------|
| LOC | <input type="checkbox"/> | Local Vendor (Has street address and holds business license within Alameda County) | MLE | <input type="checkbox"/> | Male (>50%) |
| SML | <input type="checkbox"/> | Small Business (as defined by Small Business Administration) | WHT | <input type="checkbox"/> | White (>50%) |
| FEM | <input type="checkbox"/> | Female (> 50%) | HIS | <input type="checkbox"/> | Hispanic or Latino (>50%) |
| AFA | <input type="checkbox"/> | Black or African American (>50%) | FIL | <input type="checkbox"/> | Filipino (>50%) |
| ASN | <input type="checkbox"/> | Asian (>50%) | POE | <input type="checkbox"/> | Publicly Owned Entity |
| NAT | <input type="checkbox"/> | Native Hawaiian or other Pacific Islander (>50%) | | | |
| AIN | <input type="checkbox"/> | American Indian or Alaskan Native (>50%) | | | |

The collection of ethnicity and gender data is for statistical and demographic purposes only.

Correspondence Address

Remittance Address, if different

Billing Service Name

Contact Name

Contact E-mail Address

Contact Phone Number

Contact FAX Number

Hospital/Group/Affiliation