PCMH
Patient-Centered Medical Home

CareFirst
From the CareFirst BlueCross BlueShield family of health care plans.

Attachment A: PCMH Medical Panel Information Sheet

Instructions: The following information must be completed on behalf of each practice for enrollment in the CareFirst Patient-Centered Medical Home (PCMH) program. This program is described in the Addendum to the Participation Agreements and provided to the Corporation. The practice must provide written notice of any changes to the information contained in this document within 30 days.

Please note: Each of the practices in a Virtual Medical Care Panel (VMCP) must fill out and submit Attachments A, B, and Addenda together in one packet before the application can be processed. The Panel Administrator defined below is responsible for ensuring that this process is complete.

PRACTICE INFORMATION			
Practice Name:		Practice Tax ID:	
Regional Practice Provider Number:		Practice E-mail Address*:	
Number of active Primary Care Providers (PCPs) in the practice:		Primary Office Telephone Number:	
Practice NPI Number (Type II):			
Primary Practice Address:	City:	State:	Zip:

DESIGNATED PROVIDER REPRESENTATIVE (DPR) INFORMATION **The DPR is the panel's designated provider liaison and primary contact for clinically related materials or inquiries.** Please note: Multiple practices joining a VMCP must choose one provider to serve as the primary contact for clinically related materials or inquiries.			
DPR First Name (Please print):	DPR Last Name (Please print):	DPR Phone Number:	
DPR Primary Practice Address:	City:	State:	Zip:
DPR E-mail Address*:	DPR Signature:		Date:

PANEL ADMINISTRATOR (PA) INFORMATION **The panel administrator is the person assigned by the PCMH as the administrative contact.** Please note: Multiple practices joining a Virtual Medical Care Panel must choose one person to serve as the primary contact for the entire VMCP.			
PCMH PA First Name (Please print):		PCMH PA Last Name (Please print):	
PCMH PA Primary Practice Address:	City:	State:	Zip:
PCMH PA E-mail Address*:		PCMH PA Phone Number:	

PRACTICE PORTAL ADMINISTRATOR (PPA) **The practice portal administrator is the person at each practice who will set-up practice users and assign portal roles allowing access to PCMH content appropriate for each user at their practice.**	
Portal Administrator First Name (Please print):	Portal Administrator Last Name (Please print):
Portal Administrator E-mail Address*:	Portal Administrator Phone Number:

**Email addresses starting with sales@, info@, webmaster@, etc. are considered role accounts and are blocked from our system. Please provide a personal (individual) email address when entering your information.*

(CONTINUED ON REVERSE)

Attachment A: PCMH Medical Panel Information Sheet (cont'd)

ELECTRONIC COMMUNICATION AND PATIENT ACCESS INFORMATION *Check Yes or No for the following* For detailed information regarding PCMH electronic communication and patient access information standards, please view the **program description**.		
Are you currently sending your claims electronically?	☐ Yes	☐ No
Do you currently use CareFirst Direct?	☐ Yes	☐ No
If YES, is the designated Practice Portal Administrator currently assigning user access in the practice?	☐ Yes	☐ No
If YES, please provide the current CareFirst Direct User ID: _____		
Does the practice have office visits hours after 5PM on weeknights or during weekends?	☐ Yes	☐ No
Does the practice e-prescribe?	☐ Yes	☐ No
Does the practice meet the definition for meaningful use of Electronic Medical Records as defined by CMS? To view details regarding the CMS definition for meaningful use, visit: www.cms.gov/EHRincentiveprograms.	☐ Yes	☐ No
Does the practice regularly use e-mail as a form of communication with patients?	☐ Yes	☐ No
Does the practice have e-scheduling?	☐ Yes	☐ No
Does the practice have a process for e-visits?	☐ Yes	☐ No

VIRTUAL MEDICAL CARE PANEL INFORMATION This section should only be completed by those practices forming a VMCP. Please list each practice comprising the VMCP. All practices must be located in the same geographic region to be part of a VMCP.			
1. Practice Name:	Regional Provider Number:	Tax ID:	Practice NPI Number:
2. Practice Name:	Regional Provider Number:	Tax ID:	Practice NPI Number:
3. Practice Name:	Regional Provider Number:	Tax ID:	Practice NPI Number:
4. Practice Name:	Regional Provider Number:	Tax ID:	Practice NPI Number:
5. Practice Name:	Regional Provider Number:	Tax ID:	Practice NPI Number: