



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 *Local Vendor (Has street address and holds business license within Alameda County)*

SML *Small Business (as defined by Small Business Administration)*

FEM *Female (>50%)*

MLE *Male (>50%)*

AFA *Black or African American (>50%)*

WHIT *White (>50%)*

ASN *Asian (>50%)*

HIS *Hispanic or Latino (>50%)*

NAT *Native Hawaiian or other Pacific Islander (>50%)*

FIL *Filipino (>50%)*

AIN *American Indian or Alaskan Native (>50%)*

POE *Publicly Owned Entity*

The collection of ethnicity and gender data is for statistical and demographical 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