Fortify Children's Health

REQUEST FOR INFORMATION

Practices Interested in Joining the Fortify Network

Please fill out this form and return it to support@fortifychildrens.org

PRACTICE INFORMATION

Practice Name: _____

Number of Practice Locations: _____

Practice Address(es): _____

_____

_____

Number of Providers[1]: _____

PCHM Certified (check one): Yes ☐ No ☐

Part of Call Group (check one): Yes ☐ No ☐

If yes, please list call group practices: _____

Ancillary Services Provided (please list): _____

_____

ELECTRONIC MEDICAL RECORD INFORMATION

EMR Vendor: _____

EMR Version: _____

Level of EMR Customization (check one): None ☐ Minimal ☐ Moderate ☐ Significant ☐

Ability to Track/Report Quality Data (check one): None ☐ Minimal ☐ Moderate ☐ Significant ☐

ADDITIONAL INFORMATION

Accepting New Medicaid Patients (check one): Yes ☐ No ☐

Current Value Based Agreements (check one): Yes ☐ No ☐

Part of a CIN or ACO (please list): _____

[1] Defined as licensed Physicians, CRNAs, Nurse Practitioners and Physician Assistants