CalHIPSO Provider Interest Form

If you are interested in enrolling with CalHIPSO, please complete the following information and return to Lumetra Healthcare Solutions, the Bay Area site management office at: info@lumetrasolutions.com or fax to: (415) 354-5604.

I am a: ❑ Provider ❑ Non-Provider

First Name: ____

Last Name: ____

Role:

❑ Provider ❑ Billing Specialist ❑ Educator ❑ EHR Champion ❑ EHR Vendor

❑ HIE Lead ❑ IT Consultant ❑ Office Manager ❑ Office Staff ❑ Primary Project Lead

❑ Secondary Project Lead ❑ Other

Organization: ____

Phone: ____

Email: ____

Address: ____

City: ____

Zip: ____

Provider Credentials:

❑ CNMW ❑ DDM ❑ DDS ❑ DMD ❑ DO ❑ DPM ❑ LD ❑ MD ❑ MSW ❑ NP ❑ OD
❑ PA ❑ PsyD ❑ PT ❑ RN

Specialty:

❑ Adolescent Medicine ❑ Family Practice ❑ Geriatrics ❑ General Practice

❑ Gynecology ❑ Internal Medicine ❑ OB-GYN ❑ Pediatrics

Other Specialty:

❑ Allergy ❑ Anesthesiology ❑ Audiology ❑ Breast ❑ Cardiology ❑ Counseling

❑ Dentistry ❑ Dermatology ❑ Endocrinology ❑ Gastroenterology ❑ Hematology

❑ HIV ❑ Hypertension ❑ Infectious Disease ❑ Nephrology ❑ Neurology ❑ Nutrition

❑ Oncology ❑ Ophthalmology ❑ Optometry ❑ Oral Hygiene ❑ Orthopedics

❑ Otolaryngology ❑ Pathology ❑ Physical Therapy ❑ PMR ❑ Podiatry ❑ Psychiatry

❑ Psychology ❑ Pulmonary ❑ Radiology ❑ Renal Rheumatology ❑ Social Work

❑ Sports Medicine ❑ Surgery ❑ Urology ❑ Vascular ❑ Other: ____________________