

Provider Profile Screen:
(To be completed one time for each CARE provider*)

1. Provider Name _____
2. Physical Address of Provider
 - a. Street Address _____
 - b. Street Address 2 (optional) _____
 - c. City _____
 - d. State _____
 - e. Zip _____
3. Provider Identification Numbers
 - a. Provider NPI _____
 - b. CMS Certification Number (also called OSCAR Number or _Medicare Provider's Identification Number) _____
4. Provider Type _____
Choose One: ☐ Acute Hospital ☐ LTCH ☐ IRF ☐ SNF ☐ HHA
5. Activate the ability of other authorized providers to view patient information collected while at your site? ☐ YES ☐ NO

* This information must be completed by a CARE coordinator and must be completed the first time a coordinator accesses the CARE application. This information may be updated at any time by a coordinator for the provider.