Shasta County MH Request for Staff Number

Please complete each field below. Email to: **hhsamcc@co.shasta.ca.us**

Organization Name

Office Address, City, Zip Code

Office Phone Number

Start Date

Term Date

First Name

Middle Initial

Last Name

Date of Birth

Practitioner Category/ Classification

Practitioner License Number (i.e. Medical Board, BRN,BBS)

State

Expiration Date

DEA Number

☐ Check box if currently enrolled with Medicare Part B Carrier No. CA. (NHIC)

Taxonomy

NPI

Ethnicity

If Bilingual, other languages spoken (including ASL)

Print Form

Save Form

To be completed by SCMH EHR Support

Staff Code Assigned

Rev 07/08/22