Row#	Network Name		Plan Network	Last Name	First Name	NPI		Non-CA License State	License Type
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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17									
18									
19									
20									
21									
22									
23									_
24									
25									

Row#	Specialty	Board Certified /	Clinical Encounters by Network Provider	 Provider	Network Tier	Full-Time / Part-Time	Facility	Facility NPI	HCAI ID
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19 20									
21									
22									
23									
24									
25									

Row#	Hospitalist	Provider Language 1	Provider Language 2	Provider Language 3	Practice Address (In-Person)	Practice Address 2 (In-Person)	City	County	State	ZIP Code	Phone Number
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
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15											
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17											
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19											
20											
21											
22											
23											
24											
25											

	Primary or Secondary Practice Address		Provider	<u>Telehealth</u>	Patient Location	Provider Participation Status	Status Date
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19 20							
21							
22							
23							
24							
25							

Row#	Network Name		Plan Network	Last Name	First Name	NPI	CA License	License Type	Specialty	Population Age Served
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
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18										
19										
20										
21										
22										
23										
24										
25										

	Supervising	Supervising Specialist Specialty	Clinical Encounters by Network Provider	Provider	Full-Time / Part- Time	Provider Language 1	Provider Language 2	Provider Language 3	Practice Address (In-Person)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
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20									
21									
22									
23									
24									
25									

	Practice Address 2 (In-Person)	City	County	State	ZIP Code	Primary or Secondary Practice Address	Clinic Name		Displayed in Provider Directory
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
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20									
21									
22									
23									
24									
25									

	In-Person Appointments	Telehealth Only	Telehealth Delivery Modality	Patient Location	Provider Participation Status	Status Date
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
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