Telehealth Report Form Form No. 40-271

Row #	Network Name			Subcontracted Plan Network ID	Last Name	First Name	Entity Name	NPI		CA License / Certificate
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		Provider Type Category	Type of License / Certificate			Board Certified / Eligible	<u>Clinical</u> Encounters by	Number of Enrollees Utilizing the Network Provider
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Row #	Provider Language 2	Provider Language 3	County	Number of Providers at Entity	In-Person Appointments	Telehealth Delivery Modality	Patient Location
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