

FCDS PROFILE MODIFICATION FORM

The following sections of instruction are for the completion and processing of the FCDS Profile Modification Form.

The form is available in the following formats:

- Adobe Acrobat (.pdf) - online
- Word (.doc) - by request

The FCDS Profile Modification Form is required to add a facility/profile or make changes to an existing facility/profile.

To navigate through the form use the **Tab** key.

NOTE: In PDF, each field within the document is highlighted. Move the pointer over the field for quick instructions to display.

Complete each field using the guidelines as listed below.

Today's Date:

Enter the date in the **MM/DD/YYYY** format

Facility Name:

Enter the Name (Name of facility, individual, or type). This is a limited entry field, when necessary abbreviate (i.e., Center (CTR), Medical (MED), etc)

Process Request:

ADD – To add a facility or profile

UPDATE - To update an existing facility or profile.

- **In Adobe Acrobat Format:** Select the applicable button to **ADD or UPDATE** the facility (.pdf)
- **In Word Format:** Select from the drop down menu to **ADD or UPDATE** the facility profile (.doc)

Facility Type:

Select Facility type from the drop down menu

AHCA# (up to 10 digits)

The **Agency for Health Care Administration (AHCA) ID** is the Identification number assigned by AHCA to all facilities with the **exception of Radiation Therapy Centers**.

This number can be up to 10 digits .

CLIA# (10 digits: ex. 10D9999999)

(Required field for Laboratories)

The **Clinical Laboratory Improvement Amendment (CLIA) ID** is the Identification number assigned by **Centers for Disease Control and Prevention, Division of Laboratory Science and Standards** to all laboratory facilities nationally.

NPI# (10 digits)

National Provider Identifier (NPI): Please use the NPI associated with the facility/organization.

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FCDS Facility # (4-digits)

If adding a facility leave field blank.

Once a **new** facility/profile is processed the facility will be assigned a FCDS facility number.
This information will be forwarded to the facility contact.

Option: (Required field)

Select appropriate option from the pull down list.

Reference the OPTION CODES Chart list below, to complete this section.

OPTION CODES

| <u>Option Code</u> | <u>Facility Type</u> |
|--------------------|---|
| 0 | Rural Hospital or Hospital with <35 cases per year |
| 2 | Incidence Only Hospital · Using Contract Services |
| 3 | Incidence Only Hospital · Using in House Personnel |
| 4 | Full Registry Hospital · Using in House Personnel |
| 5 | Full Registry Hospital · Using Contract Services |
| 6 | VA Hospital |
| 7 | Military Hospital |
| 8 | Psychiatric Hospital |
| A | Physician Offices with <35 cases per year |
| B | Dermatology BCC or SCC only |
| C | Closed Facility – (enter date of closure in the notes field) |
| D | Death Certificate Only |
| F | FCDS – Staff Members |
| H | County Health Department |
| L | Free - Standing Pathology Labs |
| M | Contractors |
| O | 2 nd Opinion Labs |
| P | MOH's |
| R | Free - Standing Radiation Therapy Centers |
| S | Free - Standing Ambulatory Surgery Centers |
| T | Free - Standing Ambulatory Surgery Centers <35 cases per year |
| V | Vendors |
| W | Pathology Lab Vendors |
| X | Courtesy |
| Y | Out of State |
| Z | Physician Office Death Certificate Follow-Back Process |

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FCDS Profile Information:

- This section contains all of the contact information as it pertains to the facility.
- Please complete each section.
- The credentials field is a limited entry field, please abbreviate all credentials (i.e., Batchelors of Arts Degree (BA), Certified Tumor Registrar (CTR), etc.

Notes: Enter any additional information in reference to the profile.

Complete and Submit:

To complete the form type your complete name in field indicated, enter date in field indicated, save the document, and select the submit button to send the document to the FCDS for processing (via email).

Alternate submission option: The form may also be printed and faxed to FCDS for processing at 305-243-4871.

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| TO ADD: (NEW Facility) • Please complete each section of form to add a facility. • Select ADD in the Process Request Field. • AHCA#, CLIA#, or NPI# can be obtain from administrative or business office. | | TO UPDATE: (EXISTING Facility) • Complete the Date, Profile Name and the section(s) that requires update. • Select UPDATE in the Process Request Field. | |
|---|--------------------------------------|--|--|
| Today's Date (MM/DD/YYYY): | Profile Name: (Facility Name) | | |
| Process Request: <div style="display: flex; justify-content: space-around;"> ADD (New) UPDATE (Existing) </div> | Select Facility Type: | | |
| AHCA ID#: | CLIA#: (PATH LABS ONLY) | NPI#: | |
| FCDS Facility #: (LEAVE BLANK IF ADDING FACILITY) | Option: | Date Facility Close (MM/DD/YYYY): | |
| <u>PROFILE INFORMATION</u> | | | |
| Facility Contact: | | | |
| Last Name: | First Name: | Credentials: | |
| Title: | | | |
| Mailing Address: (Address, City, ST and Zip Code) | | | |
| Phone Number: | Fax Number: | Contact Email Address: | |
| Administrator: | | | |
| Last Name: | First Name: | Credentials: | |
| Administrator Email Address: | | | |
| Title: | | | |
| Physical Address: (Address, City, ST, and Zip Code) | Phone Number: | Fax Number: | |
| NOTES: (Type additional information below) | | | |
| | | | |
| | | | |
| | | | |
| Completed By: | | | |
| Date: | | | |
| FCDS ONLY: | | | |
| Processed By: | | Date Processed: | |

SUBMIT