

STATE OF INDIANA  
ONLINE RENEWAL RECORD

Renewal Submission Date: November 10, 2021

**Person Info**

Name: Tian Xia  
License Number: 02006281A

**Address Info**

Street Address: 2542 S. Lowe  
City: Chicago  
State: IL  
Zipcode: 60616  
County: Cook  
Phone: [REDACTED]  
Email: [REDACTED]

**Question Response Summary**

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N
<b>Citizenship Status:</b>	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y

**Survey Response Summary**

01.) What is your employment status?	Actively working in a position that requires a medical degree
02.) What is your race? Mark one or more boxes.	Asian
03.) Are you of Hispanic, Latina/o, or Spanish origin?	N
04.) Where did you complete your medical degree?	Illinois
05.) Where did you complete your residency training?	Illinois
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Anesthesiology
07.) Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; 'telehealth' means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?	N
08.) What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"	N/A
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	LOMBARD
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IL
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	60148
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Office/Clinic – Multi Specialty Group
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	41 or more hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	N

16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A
17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	I do not offer a sliding fee scale
18.) What is the street address of your secondary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	I do not offer a sliding fee scale
26.) What is the street address of your tertiary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	I do not offer a sliding fee scale
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purpose of this services list is to gather information on key health issues in Indiana) Please check all that apply.	None of the above
35.) Please indicate the population groups to which you provide services:	Adolescents (ages 10-19),Adults
36.) What are your employment plans for the next 2 years?	Continue as you are