Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

LOCATION* # ☐☐

CURRENTLY PRACTICING AT THIS ADDRESS?* _____ IF NO, WHAT IS YOUR EXPECTED START DATE? _____

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9. IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* _____ TELEPHONE* FAX

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID PRIMARY TAX ID (ONE ONLY)*

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME*

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

LAST NAME*

FIRST NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

TELEPHONE* FAX

E-MAIL ADDRESS

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Practice Location Information
Supplemental Form

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Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?*

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

LAST NAME*

FIRST NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* IF YES AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

ACCEPT ALL NEW PATIENTS?*

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

ACCEPT NEW MEDICARE PATIENTS?*

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

ACCEPT NEW MEDICAID PATIENTS?*

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* IF YES

GENDER LIMITATIONS

AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Practice Location Information
Supplemental Form

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?*

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME

PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER

PRACTITIONER STATE

Practice Location Information
Supplemental Form

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Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* # ☐☐

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* _____

LANGUAGES INTERPRETED

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* _____

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* _____
- PARKING?* _____
- RESTROOM?* _____

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* _____

- TEXT TELEPHONY (TTY)* _____
- AMERICAN SIGN LANGUAGE* _____
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* _____

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* _____

- BUS* _____
- SUBWAY* _____
- REGIONAL TRAIN* _____

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? _____ IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE) _____

RADIOLOGY SERVICES? _____ IF YES, PROVIDE X-RAY CERTIFICATION TYPE _____

EKGS? _____	ALLERGY INJECTIONS? _____	ALLERGY SKIN TESTING? _____	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? _____
DRAWING BLOOD? _____	AGE APPROPRIATE IMMUNIZATIONS? _____	FLEXIBLE SIGMOIDOSCOPY? _____	TYMPANOMETRY/ AUDIOMETRY SCREENING? _____
ASTHMA TREATMENT? _____	OSTEOPATHIC MANIPULATION? _____	IV HYDRATION/ TREATMENT? _____	CARDIAC STRESS TEST? _____
PULMONARY FUNCTION TESTING? _____	PHYSICAL THERAPY? _____	CARE OF MINOR LACERATIONS? _____	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? _____ IF YES, WHAT CLASS/CATEGORY DO YOU USE? _____

IF YES, WHO ADMINISTERS IT?

LAST NAME _____ FIRST NAME _____

TYPE OF PRACTICE (SELECT ONE ONLY)* _____

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

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Practice Location Information
Supplemental Form

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Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* # ☐☐

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	PROVIDER TYPE (CODE PG 36)	
LAST NAME	SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	PROVIDER TYPE (CODE PG 36)	

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME	SPECIALTY CODE
FIRST NAME	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE
FIRST NAME	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE
FIRST NAME	PROVIDER TYPE (CODE PG 36)
LAST NAME	SPECIALTY CODE
FIRST NAME	PROVIDER TYPE (CODE PG 36)

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