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.

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

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

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*

TELEPHONE* | FAX

E-MAIL ADDRESS

NOTE:

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

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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

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

ELECTRONIC BILLING CAPABILITIES?* _____ BILLING DEPARTMENT (IF HOSPITAL-BASED) _____

CHECK PAYABLE TO* _____

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

LAST NAME* _____

FIRST NAME* _____

NUMBER* _____ STREET* _____ SUITE/BUILDING _____

NOTE:

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

CITY* _____ STATE* _____ ZIP CODE* _____

TELEPHONE* _____ FAX _____

E-MAIL ADDRESS _____

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									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

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

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 _____

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Practice Location Information
Supplemental Form

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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

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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 | LANGUAGE | LANGUAGE | LANGUAGE | LANGUAGE

INTERPRETERS AVAILABLE?*

LANGUAGES INTERPRETED

LANGUAGE | LANGUAGE | LANGUAGE | LANGUAGE

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

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)

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