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?*: YES

IF NO, WHAT IS YOUR EXPECTED START DATE?:

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

Access Healthcare Physicians LLC
GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER*	STREET*	SUITE/BUILDING
	5362 Spring Hill Drive	

CITY*	STATE*	ZIP CODE*
Spring Hill	Florida	346064562

SEND GENERAL CORRESPONDENCE HERE?*: NO

TELEPHONE*: +1-3526883379

FAX: +1-3523981333

yharris@accesshealthcarellc.net
OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID:

GROUP TAX ID:

PRIMARY TAX ID (ONE ONLY)*: Group

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.

Brown-Harris
LAST NAME*

Yolanda
FIRST NAME*

TELEPHONE*: +1-3526883379

FAX: +1-3523981333

yharris@accesshealthcarellc.net
E-MAIL ADDRESS

Billing Contact

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

Patel
LAST NAME*

Val
FIRST NAME*

NUMBER*	STREET*	SUITE/BUILDING
	PO Box 919469	

CITY*	STATE*	ZIP CODE*
Orlando	Florida	32891-9469

NOTE:

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

TELEPHONE*: +1-7278232188

FAX: +1-7278280723

generalinquiry@medenet.net
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?*: YES

BILLING DEPARTMENT (IF HOSPITAL-BASED):

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

CHECK PAYABLE TO*: Access Healthcare Physicians, LLC

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

LAST NAME*: Patel

FIRST NAME*: Val

NUMBER*:

STREET*: PO Box 919469

SUITE/BUILDING:

CITY*: Orlando

STATE*: Florida

ZIP CODE*:

TELEPHONE*: +1-7278232188

FAX: +1-7278280723

E-MAIL ADDRESS*: generalinquiry@medenet.net

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	08:00		17:00		FRIDAY	08:00		17:00	
TUESDAY	08:00		17:00		SATURDAY	Day Off		Day Off	
WEDNESDAY	08:00		17:00		SUNDAY	Day Off		Day Off	
THURSDAY	08:00		17:00						

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?*: YES

IF YES: YES

AFTER HOURS BACK OFFICE TELEPHONE: +1-3526883379

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*: YES

ACCEPT ALL NEW PATIENTS?*: YES

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*: YES

ACCEPT NEW MEDICARE PATIENTS?*: YES

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*: YES

ACCEPT NEW MEDICAID PATIENTS?*: YES

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN:

ARE THERE ANY PRACTICE LIMITATIONS?*: NO

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?* YES

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

BUILDING?* YES
PARKING?* YES
RESTROOM?* YES

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* NO

TEXT TELEPHONY (TTY)*
AMERICAN SIGN LANGUAGE* NO
MENTAL/PHYSICAL IMPAIRMENT SERVICES*

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES

BUS* YES
SUBWAY* NO
REGIONAL TRAIN* NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

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

RADIOLOGY SERVICES? NO
IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS?	YES	ALLERGY INJECTIONS?	YES	ALLERGY SKIN TESTING?	NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)?	YES
DRAWING BLOOD?	YES	AGE APPROPRIATE IMMUNIZATIONS?	YES	FLEXIBLE SIGMOIDOSCOPY?	NO	TYMPANOMETRY/ AUDIOMETRY SCREENING?	NO
ASTHMA TREATMENT?	NO	OSTEOPATHIC MANIPULATION?	NO	IV HYDRATION/ TREATMENT?	YES	CARDIAC STRESS TEST?	YES
PULMONARY FUNCTION TESTING?	NO	PHYSICAL THERAPY?	YES	CARE OF MINOR LACERATIONS?	YES		

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? NO
IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

LAST NAME | FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* Multi-Specialty Group

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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