Access Health Care - Provider Profile

Provider Name:

NPI:	**TIN:45-1444883**	
Cred. Date (Initial):	**Recred Date Cycle 1**	**Recred Date Cycle 2**
Medical License:	**DEA:**	

Education/Personal Information:

Medical Education: (School Name, Yrs Attended, Degree Earned)					
Internship: (Facility, Specialty, From/To)					
Residency(ies) (Facility, Specialty, From/To)					
Fellowship(s)					
SSN:		**DOB:**		**Ethnic Origin**	
Gender		**Provider Languages:**			

Provider Information:

PCP or Specialist:		**Primary Specialty:**		**Secondary Specialty:**	
Board Certified:		**Certified in: (list effective dates)**			
Covering Physicians:					
Hospital Affiliations: (list effective dates)					

Practice Information:

Location 1: Phone/Fax:					
Office Hours	**M:**	**Tu:**	**W:**	**Th:**	**Fr:**
Billing Information:	**PO BOX 636233, CINCINNATI, OHIO 45263-6233**				
	727-823-2188		**727-828-0723**		
Location 2: Phone/Fax:					
Office Hours	**M:**	**Tu:**	**W:**	**Th:**	**Fr:**
Billing information:					