

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

NO

IF NO, WHAT IS
YOUR EXPECTED
START DATE?

M M D D Y Y Y Y

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?*

YES

NO

TELEPHONE*

FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID

GROUP TAX ID

PRIMARY
TAX ID
(ONE ONLY)*

USE INDIVIDUAL
TAX ID

USE GROU
TAX ID

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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Section 4

Practice Location Information - Page 2 of 5

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC
BILLING
CAPABILITIES?*

☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

CHECK PAYABLE TO*

LAST NAME*

FIRST NAME*

NUMBER*

STREET*

SUITE/BUILDING

CITY*

STATE*

ZIP CODE*

TELEPHONE*

FAX

E-MAIL ADDRESS

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

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	<input type="text"/>		<input type="text"/>		FRIDAY	<input type="text"/>		<input type="text"/>	
TUESDAY	<input type="text"/>		<input type="text"/>		SATURDAY	<input type="text"/>		<input type="text"/>	
WEDNESDAY	<input type="text"/>		<input type="text"/>		SUNDAY	<input type="text"/>		<input type="text"/>	
THURSDAY	<input type="text"/>		<input type="text"/>						

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

☐ YES ☐ NO

☐ ANSWERING SERVICE

☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE

☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?*

☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?*

☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?*

☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?*

☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?*

☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?*

☐ YES ☐ NO

IF ANY OF THE
ABOVE VARIES BY
PLAN, EXPLAIN

ARE THERE ANY
PRACTICE LIMITATIONS?*

IF YES

☐ YES ☐ NO

GENDER LIMITATIONS

☐ MALE ONLY

☐ NONE

AGE LIMITATIONS

☐ MINIMUM AGE

☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

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Section 4		Practice Location Information - Page 4 of 5																																																		
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	<table border="0"><tr><td>DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING</td><td>DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*</td><td>ACCESSIBLE BY PUBLIC TRANSPORTATION?*</td></tr><tr><td>BUILDING?* <input type="text"/> YES <input type="text"/> NO</td><td>TEXT TELEPHONY (TTY)* <input type="text"/> YES <input type="text"/> NO</td><td>BUS* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>PARKING?* <input type="text"/> YES <input type="text"/> NO</td><td>AMERICAN SIGN LANGUAGE* <input type="text"/> YES <input type="text"/> NO</td><td>SUBWAY* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td>RESTROOM?* <input type="text"/> YES <input type="text"/> NO</td><td>MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="text"/> YES <input type="text"/> NO</td><td>REGIONAL TRAIN* <input type="text"/> YES <input type="text"/> NO</td></tr><tr><td><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></td><td><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></td><td><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></td></tr><tr><td>OTHER HANDICAPPED ACCESS</td><td>OTHER DISABILITY SERVICES</td><td>OTHER TRANSPORTATION ACCESS</td></tr></table>			DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING	DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?*	ACCESSIBLE BY PUBLIC TRANSPORTATION?*	BUILDING?* <input type="text"/> YES <input type="text"/> NO	TEXT TELEPHONY (TTY)* <input type="text"/> YES <input type="text"/> NO	BUS* <input type="text"/> YES <input type="text"/> NO	PARKING?* <input type="text"/> YES <input type="text"/> NO	AMERICAN SIGN LANGUAGE* <input type="text"/> YES <input type="text"/> NO	SUBWAY* <input type="text"/> YES <input type="text"/> NO	RESTROOM?* <input type="text"/> YES <input type="text"/> NO	MENTAL/PHYSICAL IMPAIRMENT SERVICES* <input type="text"/> YES <input type="text"/> NO	REGIONAL TRAIN* <input type="text"/> YES <input type="text"/> NO	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OTHER HANDICAPPED ACCESS	OTHER DISABILITY SERVICES	OTHER TRANSPORTATION ACCESS																															
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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		
	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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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 <u>NOT</u> PARTNERS/ASSOCIATES AT THIS PRACTICE		
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