

Practice Location Information - Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.				PRACTICE LOCATION of	
TYPE OF SERVICE PROVIDED <input type="checkbox"/> Solo Primary Care <input type="checkbox"/> Solo Specialty Care <input type="checkbox"/> Group Primary Care <input type="checkbox"/> Group Single Specialty <input type="checkbox"/> Group Multi-Specialty					
GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY			GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9		
PRACTICE LOCATION ADDRESS <input type="checkbox"/> Primary					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX NUMBER		E-MAIL	
BACK OFFICE PHONE NUMBER		SITE-SPECIFIC MEDICAID NUMBER		TAX ID NUMBER	
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER		GROUP NAME CORRESPONDING TO TAX ID NUMBER			
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NO, EXPECTED START DATE? (MM/DD/YYYY)		DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OFFICE MANAGER OR STAFF CONTACT			PHONE NUMBER		FAX NUMBER
CREDENTIALING CONTACT					
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX NUMBER		E-MAIL	
BILLING COMPANY'S NAME (IF APPLICABLE)				BILLING REPRESENTATIVE	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX NUMBER		E-MAIL	
DEPARTMENT NAME IF HOSPITAL-BASED		CHECK PAYABLE TO		CAN YOU BILL ELECTRONICALLY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOURS PATIENTS ARE SEEN					
Monday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Tuesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Wednesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Thursday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Friday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Saturday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
Sunday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon:	Evening:	
DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE? <input type="checkbox"/> Answering Service <input type="checkbox"/> Voice mail with instructions to call answering service <input type="checkbox"/> Voice mail with other instructions <input type="checkbox"/> None					
THIS PRACTICE LOCATION ACCEPTS <input type="checkbox"/> all new patients <input type="checkbox"/> existing patients with change of payor <input type="checkbox"/> new patients with referral <input type="checkbox"/> new Medicare patients <input type="checkbox"/> new Medicaid patients					
IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.					
PRACTICE LIMITATIONS <input type="checkbox"/> Male only <input type="checkbox"/> Female only Age: <input type="checkbox"/> Other:					
DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information for each staff member:					
NAME		PROFESSIONAL DESIGNATION		STATE & LICENSE NUMBER	
NAME		PROFESSIONAL DESIGNATION		STATE & LICENSE NUMBER	