

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 <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;">Monday</td> <td style="width: 15%;"><input type="checkbox"/> No Office Hours</td> <td style="width: 25%;">Morning:</td> <td style="width: 25%;">Afternoon:</td> <td style="width: 20%;">Evening:</td> </tr> <tr> <td>Tuesday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> <tr> <td>Wednesday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> <tr> <td>Thursday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> <tr> <td>Friday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> <tr> <td>Saturday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> <tr> <td>Sunday</td> <td><input type="checkbox"/> No Office Hours</td> <td>Morning:</td> <td>Afternoon:</td> <td>Evening:</td> </tr> </table>						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:
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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 NO.																																				
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