**If you have multiple locations, copy this form and fill out one for each location**

**If information is the same (billing, tax id) as the primary office, just indicate (SA)**

Legal Name of Corporation (As it appears on W-9) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Multi - Specialty

Provide Specialty

Corporation Sole Proprietor Partnership LLC Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incorporation Date (*mm/dd/yyyy)(if applicable)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State License or Certificate #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Renewal date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License/Certification N/A

Primary office name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Correspondence Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentialing/Manger\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attach a list of all practitioners at this practice site.

|  |  |  |  |
| --- | --- | --- | --- |
| **Business Hours at this location:** | | | |
| Weekday | Office Hours | Weekday | Office Hours |
| Monday |  | Friday |  |
| Tuesday |  | Saturday |  |
| Wednesday |  | Sunday |  |
| Thursday |  |  |  |

Within how many days will a patient receive an appointment in this office?

Elective visit \_\_\_\_\_\_\_\_\_\_\_

Urgent problem \_\_\_\_\_\_\_\_\_\_\_

Routine visit \_\_\_\_\_\_\_\_\_\_\_

Are new patients accepted into the practice? Yes No

Accept all new patients Yes No

Accept existing new patients with change of payer Yes No

Accept new patients from physician referral Yes No

Accept new Medicare patients Yes No

Accept new Medicaid patients Yes No

Does this office accept walk-in patients? Yes No

If this information varies by health plan, please provide explanation: Yes No

Do you provide 24 hour, 7-day per week coverage for this site? Yes No

If yes, indicate type (ex: answering machine, voice mail with instructions to call answering service, voice mail with other instructions.):

Do midlevel practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician practitioners care for patients in your practice? Yes No

If yes, provide the following information for each staff member: (Attach another page if additional space is needed.)

|  |  |  |
| --- | --- | --- |
| **Name** | **Professional Designation** | **State License number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

List non-English languages spoken by office staff : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are interpreters available? Yes No

If yes, please languages:

Does this office meet ADA accessibility standards? Yes No

Does this office provide handicapped accessibility for each of the following:

Building Yes No

Parking Yes No

Restroom Yes No

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this site provide other services for the disabled? Yes No

If yes, indicate type:

\_\_\_\_\_ Text Telephone (TTY)

\_\_\_\_\_ American Sign Language (ASL)

\_\_\_\_\_ Mental/Physical impairment service

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this site accessible by public transportation? Yes No

If yes, indicate type:

\_\_\_\_\_Bus

\_\_\_\_\_ Subway

\_\_\_\_\_ Regional Train

\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this site provide childcare services? Yes No

Does this site qualify as a minority business enterprise? Yes No

Business Entity Rating (Please check one)

Profit Non-Profit Not Applicable

Business Entity Control (Please check one)

State Private Public City Charity Not Applicable

Fiscal Year begin date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laboratory Services Yes No

CLIA or another accrediting/certifying program? Yes No

Cert # \_\_\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_\_\_\_\_\_

Radiology Services Yes No

X- ray Certification? Yes No

Fluoroscopy Yes No

Radiography Yes No

Other Yes No

EKG Yes

No Laceration Repair Yes No

Pulmonary function testing Yes No

Allergy injections Yes No

Allergy Skin testingYes No

Office gynecology Yes No

Draw blood Yes

No Immunizations Yes No

Flexible Sigmoidoscopy Yes No

Audiometry Yes No

Osteopathic Manipulation Yes No

Intravenous Treatment Yes No

Cardiac Stress Tests Yes No

Physical Therapy Yes No

Is anesthesia administered in your office? Yes No

What class/category of anesthesia is used?

Anesthesia administered by:

Anesthesia administered by Last Name:

Anesthesia administered by First Name:

**Group Medicare # (PTAN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ATTACHMENT LIST:**

**\_\_\_\_\_\_\_ GROUP MALPRACTICE CERTIFICATE WITH NAMES OF ALL PROVIDERS OR**

**DEEMING LETTER**

**\_\_\_\_\_\_\_ W-9 FORM**

**\_\_\_\_\_\_\_ IRS LETTER**

**\_\_\_\_\_\_\_ CP575 OR LETTER 147C OR TAX COUPON**

**\_\_\_\_\_\_\_ 3RD PARTY PAYER CONTRACTS/AGREEMENTS**

**\_\_\_\_\_\_\_ ORGANIZATIONAL NPI LETTER**

**\_\_\_\_\_\_\_ COMPANY LETTERHEAD**