



**PROVIDER INFORMATION**

PRACTICE NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

NAME OF CONTACT PERSON: \_\_\_\_\_

1. GROUP NPI: \_\_\_\_\_ TAX ID: \_\_\_\_\_

2. INDIVIDUAL INFORMATION:

DR. NAME: \_\_\_\_\_ TAX ID: \_\_\_\_\_

NPI: \_\_\_\_\_

DR. NAME: \_\_\_\_\_ TAX ID: \_\_\_\_\_

NPI: \_\_\_\_\_

Are you currently contracted with any insurance providers? NO: \_\_\_\_\_ YES: \_\_\_\_\_

If yes, please list Name and any acct#'s assigned

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

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