PRACTICE FORM

(Please Print)

GROUP / FACILITY / PRACTICE INFORMATION

Practice Name:		
☐ Physician Practice (Please include Physician Data Sheet) ☐ Free Standing Facility ☐ Acute Care Hospital	☐ Specialty Hospital ☐ Other (please describe)	Specialties:

Federal Tax ID:	Group NPI:	JCAHO Number:	Bill on: ☐ HCFA-1500 ☐ UB-92
State License (Facility / Hospital Only):			
Web Site:			

MALPRACTICE INSURANCE

Please provide copy of Malpractice Face Sheet

Carrier Name:	Policy Number:	
Effective Date:	Per Claim Amount:	Aggregate Amount:

ADDRESS INFORMATION

Address 1 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:
Address 2 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:
Address 3 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:
Address 4 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:
Address 5 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:
Address 6 ☐ Service ☐ Billing ☐ Mailing			Tax ID (If Different):		
Street:			Address:		
City:	State:	Zip:	Zip4:	Phone:	Fax:

CONTACT INFORMATION

First	MI:	Last:	
Title:		Phone:	Fax:
Email:			