



PRACTICE FORM

(Please Print)

GROUP / FACILITY / PRACTICE INFORMATION

Practice Name:

<input type="checkbox"/> Physician Practice (Please include Physician Data Sheet)	<input type="checkbox"/> Specialty Hospital	Specialties:
<input type="checkbox"/> Free Standing Facility	<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Acute Care Hospital		

Federal Tax ID:	Group NPI:	JCAHO Number:	Bill on: <input type="checkbox"/> HCFA-1500 <input type="checkbox"/> UB-92
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State License (Facility / Hospital Only):

Web Site:

MALPRACTICE INSURANCE

Please provide copy of Malpractice Face Sheet

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

Address 1 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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Address 2 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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Address 3 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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Address 4 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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Address 5 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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Address 6 <input type="checkbox"/> Service <input type="checkbox"/> Billing <input type="checkbox"/> Mailing	Tax ID (If Different):
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Street:	Address:
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City:	State:	Zip:	Zip4:	Phone:	Fax:
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CONTACT INFORMATION

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