Practice Information Addendum

REMINDER THAT THIS INFORMATION IS BEING PROVIDED TO HEALTH PLANS

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			

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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:

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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 testing ☐Yes ☐No
Office gynecology ☐Yes ☐No

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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**