Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.*

PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS
☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

Practice Location Information - continued

NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE
NAME NUMBER	PROFESSIONAL DESIGNATION	STATE & LICENSE

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ Please *check this box and complete and submit Attachment F if you have other practice locations.*