NAME

Reset Form

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

LOCATION* #

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

PREVIOUS OR FUTURE START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* ☐ YES ☐ NO

TELEPHONE* | FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID | GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* | M.I.

TELEPHONE* | FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LAST NAME*

FIRST NAME* | M.I.

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

TELEPHONE* | FAX

E-MAIL ADDRESS

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* YES NO

IF YES: ANSWERING SERVICE; VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE; VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO

IF YES

GENDER LIMITATIONS: MALE ONLY; FEMALE ONLY; NONE

AGE LIMITATIONS: MINIMUM AGE; MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* YES NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

Mid-Level Practitioners

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

- LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)
- RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE
- EKGS? YES NO
- DRAWING BLOOD? YES NO
- ASTHMA TREATMENT? YES NO
- PULMONARY FUNCTION TESTING? YES NO
- ALLERGY INJECTIONS? YES NO
- AGE APPROPRIATE IMMUNIZATIONS? YES NO
- OSTEOPATHIC MANIPULATION? YES NO
- PHYSICAL THERAPY? YES NO
- ALLERGY SKIN TESTING? YES NO
- FLEXIBLE SIGMOIDOSCOPY? YES NO
- IV HYDRATION/ TREATMENT? YES NO
- CARE OF MINOR LACERATIONS? YES NO
- ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
- TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
- CARDIAC STRESS TEST? YES NO

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME | FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* # ____

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

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