**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<br>NUMBER | PROFESSIONAL DESIGNATION | STATE & LICENSE |
|---|---|---|
| NAME<br>NUMBER | PROFESSIONAL DESIGNATION | STATE & LICENSE |
| NAME<br>NUMBER | PROFESSIONAL DESIGNATION | STATE & LICENSE |
| NAME<br>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.*