Provider Data Form

Decent

Group Name:

Tax ID:

Provider

Provider Last Name:

Provider First Name:

Provider Middle Initial:

Individual NPI:t

Group NPI:

PCP or Specialist

Primary Specialty:

Additional Specialty:

Provider Type (MD, DO, PhD, LCSW, LPC, etc.):

Primary Office Street Address:

Suite #:

Primary Office City:

Primary Office State:

Primary Office Zip Code:

Primary Phone:

Primary Fax:

Point of Contact

Point of Contact Name

Point of Contact Email:

Billing

Billing Street Address:

Suite #:

Billing City:

Billing State:

Billing Zip Code:

Billing Phone:

Billing Fax:

Please add additional service locations on page 2 of this form. Be sure to include phone, fax, office hours, and handicap accessibility

Please complete one form for each practitioner in the practice. For assistance, call ***1-866-432-7887***

Additional Addresses

** Circle Address Type that Applies.*

Additional Address is: (Primary, Billing, Mailing, or Patient)

Street Address:			Suite #:
City:	State:	County:	Zip Code:
Phone Number:		Fax Number:	Handicap Accessible (Yes/No)

Additional Address is: (Primary, Billing, Mailing, or Patient)

Street Address:			Suite #:
City:	State:	County:	Zip Code:
Phone Number:		Fax Number:	Handicap Accessible (Yes/No)

Additional Address is: (Primary, Billing, Mailing, or Patient)

Street Address:			Suite #:
City:	State:	County:	Zip Code:
Phone Number:		Fax Number:	Handicap Accessible (Yes/No)