

## **Practice Information**

**Name:**

**Tax ID #:**

**Social Security Number *(if different from Tax ID#):***

**Name of Practice *(if applicable):***

**Is practice incorporated?**

**Service Address *(office where you see clients):***

**Service Address phone:**

**Service Address fax:**

*(Note: If you have more than one service address, please include all service addresses, phone, and fax #'s. Please indicate which days you are at which office.)*

**Billing Address *(where checks are sent, if different from above):***

**Billing Address phone *(if different from above):***

**Billing Address fax *(if different from above):***

**Your date of birth:**

**Your license #:**

**Your degree(s):**

**E-mail address:**

**Mobile phone # *(if this is a good way to reach you):***

**Home phone # *(if this is a good way to reach you and you are OK giving it out):***

## Practice Information

Name:

Standard Billing Fees:

90801:

90806:

90847/46:

90853 (*if applicable*)

90862:

90805:

90807:

90809:

If there are any other procedures you provide with patients (*e.g. testing*), please list the procedure code & rate here:

Code:

Fee:

What insurance panels do you participate on? Please list them, along with any participating-provider numbers you might have.

## **Practice Information**

**Name:**

**NPI #: (Type 1 – individual)**

**NPI #: (Type 2 – organizational)**

**Medicare #:**

**Medicaid #:**

**BC/BS #:**

**Please list any usernames & passwords to insurance company websites:**

**Do you have a CAQH account:**    \_\_\_\_\_ **Yes**                      \_\_\_\_\_ **No**

**If yes, please list your account # (login ID #):**

**Please indicate your password:**