

## Health Network One Provider Information Form for PT/OT/ST

Office Location A													
Practice Name:													
Address 1:					Address 2:								
City:					State Z								
Phone:			Fax	<b>(</b> :	Emo			Eme	nergency Phone:				
Email:					Contact:								
Group Location Medicaid Id:						Group Location Medicare Id:							
Group/Location NP	l:		Age	Age Ranges Seen:			Lang	Languages Spoken(Other than English):					
Hours													
	Open	Close	Oper	n Close			C	Open	Close	Open	ì	Close	
Monday					Thu	rsday	У						
Tuesday					Frid	ay							
Wednesday					Satu	ırday	/						
				<u> </u>	Sunday								
Billing Information	(Make Pa	yments P	ayable	e To)									
Payee Name:													
Tax Id:					Billing NPI (if different):								
Address 1:				Address 2:									
City:					State					Zip			
Phone: Fax:				Email:									
1099 Address (if dif	ferent fro	om billing	inforr	mation)									
Name:													
Address 1: Address 2:													
City:						State					Zip		
Phone: Fax:					Email:								

## **Additional Office Locations**

Office Location 2												
Practice Name:												
Address 1:					Add	dress 2:						
City:					State				Zip			
Phone:			Fax:		1		Eme	rgency P	hone:			
Email:					Conta	ct:						
Group Location Medicaio	d Id:				Group	Locatio	on Medi	care Id:				
Group/Location NPI:		Age Ranges Seen: L			Languages Spoken(Other than English):							
Hours												
110013	Open	Close	Open	Close			Open	Close	Open	Close		
Monday	- 1		- F		Thu	rsday	- P - M		- C p - C - C			
Tuesday					Frida	-						
Wednesday					Satu	rday						
					Sund							
Office Location 3												
Practice Name:												
Address 1:					Ad	dress 2:						
City:					State Zip							
Phone: Fax			Fax:			Emergency Phone:						
Email:					Contact:							
Group Location Medicaid Id:						Group Location Medicare Id:						
Phone:  Email:  Group Location Medicaid Id:  Group/Location NPI:  Hours			Age Ran	iges See	n:	n: Languages Spoken(Other than English):						
Hours						l						
	Open	Close	Open	Close			Open	Close	Open	Close		
Monday					Thu	rsday						
Tuesday					Fric	lay						
Wednesday					Sati	urday						
					Sun	day						

Therapist Roster									
Last Name	First Name & Middle Initial	Individual NPI (10 digits)	State License #	Medicaid Number	Date of Birth	Specialties & Services*	Office Locations		
Doe	John	1234567890	PT1234	88888888	01/01/60	1, 2, 11, 12	1, 3		
						_			

\*Specialties and Services

1. PT - Adults 7. STROKE 12. PED OT 8. WOUND CARE 2. OT - Adults 13. PED ST 3. ST - Adults with Whirlpool (not Aquatic) 14. PARALLEL BARS 4. HAND/CHT 9. AQUATIC 15. PED DEVELOPMENTAL 10. OB/GYN PT 5. LYMPHEDEMA 16. NDT CERTIFICATION 6. NEURO 11. PED PT 17. BALANCE & VESTIBULAR REHAB

Please copy this page to list additional therapists.

Note: <u>Please submit along with this form copies of Professional License and Professional Liability Insurance for all therapists.</u>