

Provider Data Form

Complete one data sheet per Provider. Please make copies of this form as needed.

Tax ID #: _____

NPI #: _____

Provider Last Name _____

Provider First Name _____

Provider Middle Name _____

Provider's Degree: _____ Language Spoken (Other than English): _____ Gender: Male Female

Affiliated Hospitals

1. _____ 2. _____ 3. _____

Check here if you are a PCP (Primary Care Provider) IPA/PHO Name: _____

Primary Taxonomy Code: _____ Primary Specialty: _____

Secondary Taxonomy Code: _____ Secondary Specialty: _____

Office Location

Check all that apply: Use as Payment (Remit To) Address
 Not accepting new Patients Do not print in Directory

Practice Name: _____
Street Address (1): _____
Street Address (2): _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Contact Person
Last Name: _____
First Name: _____
Title or Position: _____
Phone: _____
E-mail _____

Additional Office Locations

Check all that apply: Use as Payment (Remit To) Address
 Not accepting new Patients Do not print in Directory

Check all that apply: Use as Payment (Remit To) Address
 Not accepting new Patients Do not print in Directory

Practice Name: _____
Street Address (1): _____
Street Address (2): _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Practice Name: _____
Street Address (1): _____
Street Address (2): _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Payment (Remit To) Address (If different than Office Location)

Practice Name: _____
Street Address (1): _____
Street Address (2): _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Contact Person
Last Name: _____
First Name: _____
Title or Position: _____
Phone: _____
E-mail _____