



Contract Type: Medicaid Medicare Both Medicaid & Medicare

Practice Name: _____

Provider Type: PCP Specialist Ancillary Facility

Legal Entity Name: _____

Group NPI (10 char), if applicable: _____ **Group/Solo TIN/EIN # (9 char):** _____

Contact Person: _____

Contact Email: _____

	Practice Name (as it will appear in Provider Directory)	Street Address	Bldg # and/or Ste #	City	State	Zip Code	County	Telephone w/ Area Code	Fax Number w/ Area Code	Email
Practice Location 1										
Practice Location 2										
Practice Location 3										
Practice Location 4										
Practice Location 5										
Practice Location 6										
Practice Location 7										
Practice Location 8										

