

PROVIDER DEMOGRAPHIC INFORMATION:			
**If provider would like to list multiple facilities, please fill out a separate application for each location.			
Legal Business Name:			
DBA Name (if applicable):		Corporate Status (LLC, Corporation, Partnership, etc.):	
Applicants Name:		License No:	Federal Tax ID Number:
National Provider Identifier (NPI): Individual:		NPI Organization:	
Is the provider a unit of a larger entity/ agency/corporation or network?	If yes, please enter name here:		
NPI Number (if applicable):			
Mailing Address:		Suite #:	
City:	County:	State:	Zip + 4 digit postal code:
Telephone Number:		Fax Number:	
Company Web Site URL:			
OFFICE CONTACT: Please list the person you would like us to contact when needing updated information for your managed care file, if different than above.			
Contact (if different than applicant):		Contact Phone Number:	
Contact Fax Number:		Contact E-mail Address:	
BEST TIME TO CALL DESIGNATED CONTACT FOR INFORMATION			
Mon-Thur. _____	Fri. _____	Sat. _____	Sun. _____
BILLING INFORMATION (if applicable):			
Billing Co. Name:		Billing Co. Address:	
City:	County:	State:	Zip:
Billing Co. Phone:		Billing Co. Fax:	
Billing Co. Contact:		Billing Co. Phone:	
Billing Co. E-mail:		Billing Co. Web Site or URL:	
EXPIRATION DATES REFERAL: Please provide month, day and year of renewal (01/01/2010 for example).			
Providers State License Renewal Date:			
Providers Business/General Liability Insurance Renewal Date:			
Providers Professional/Malpractice Insurance Renewal Date:			
City/County Business License Renewal Date:			
Equipment Calibration Renewal Date:			
Equipment Calibration Renewal Date:			
Equipment Calibration Renewal Date:			