

MEDICAL FACILITY PROVIDER INFORMATION FORM

Facility/Company Name: _____

PROVIDER INFORMATION

MALPRACTICE COVERAGE

Medicaid Provider Number: _____

Insurer: _____

Tax Identification Number: _____

Policy Number: _____

State License Number: _____

Policy Limits: _____

Medicare Provider Number: _____

Expiration Date: _____

PAYEE INFORMATION

Payee Name: _____
(The payee name as it should appear on checks)

Tax Identification # _____

Mailing Address: _____
Street Address or PO Box City State Zip

Contact Person: _____ Phone # _____ Fax # _____

FACILITY LOCATIONS

Location I

Location II

Location III

Office Name _____

Office Name _____

Office Name _____

Street Address _____

Street Address _____

Street Address _____

City/State/Zip _____

City/State/Zip _____

City/State/Zip _____

Office Contact/Phone # _____

Office Contact/Phone # _____

Office Contact/Phone # _____

Fax Number _____

Fax Number _____

Fax Number _____

Hours of Operation

Mon. _____

Hours of Operation

Mon. _____

Hours of Operation

Mon. _____

Tues. _____

Tues. _____

Tues. _____

Wed. _____

Wed. _____

Wed. _____

Thurs. _____

Thurs. _____

Thurs. _____

Fri. _____

Fri. _____

Fri. _____

Sat. _____

Sat. _____

Sat. _____

Sun. _____

Sun. _____

Sun. _____