Practice Profile for Directory and Claims Payment

Territory: _____
Provider Rep: _____

Your Directory Profile

Provider Name: _____
Practice Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ Fax: _____
Office Hours: _____

PCP/Spec: _____
Primary Specialty _____
Secondary: _____
Third: _____

Professional Practice Interest-Focus

_____

Ex: An Orthopeadic Surgeon whose primary focus is Backs

Languages Spoken by:
Physician _____
Staff _____

Practice Limitations: _____
Age Range: _____
Gender Restriction: _____

- ☐ New Patients with Referral
- ☐ New Medicare Patients
- ☐ All New Patients
- ☐ Existing Pts - Change in Payor
- ☐ New Medicaid Patients

Billing/Payment Information

Billing Addres _____

Tax/EIN No: _____

Checks Payable to:

_____

Phone : _____
Fax: _____

Credentialing

Contact Person: _____
Phone: _____
e-mail: _____

Office Manager

Office Mgr: _____
OM Phone: _____
OM Fax: _____
E-mail 1: _____

Same for all locations? ☐ Yes ☐ No

Completed By:

_____ Date: _____

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