ATTACHMENT B

Participating Entity and Provider Information

(Please complete 1 form per Practice location)

Practice Information

Practice Name: _____

Address: _____
Street Address Suite #

_____ _____ _____
City State Zip Code +4 County

Office Phone: _____ Number of Clinicians: _____ TIN/SSN/EIN: _____

Group NPI: _____ Practice Specialty (Choose 1):

Practice Type (Choose 1):

- ○ Primary Care
- ○ Specialist

- ○ Internal
- ○ Family
- ○ Geriatric
- ○ Pediatric

- ○ FQHC
- ○ OB/GYN
- ○ Behavior Health
- ○ Other_____

Point of Contact (POC)

Practice Point of Contact: _____ POC Phone Number: _____

POC E-mail: _____

Provider Information

Providers Name:	Provider NPI	EP Type:	Specialty