

Organizational Provider Demographic Application

Demographic / General Information

D.B.A. (as signage indicates): _____

Corporate Name (as assigned TIN on W-9): _____

Facility Tax Identification Number: _____

Is the facility owned in whole or in part by a hospital system? Yes No Hospital System: _____

Is the facility a participating Medicare provider? Yes No Medicare Number: _____

Is the facility a participating Medicaid provider? Yes No Medicaid Number: _____

Please indicate the service type(s) at each address:

- | | | |
|-------------------------------------------------------------|-----------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Rehab – OT |
| <input type="checkbox"/> Audiology – Hearing Aid Dealers | <input type="checkbox"/> Indep. Diagnostic Services | <input type="checkbox"/> Rehab – PT |
| <input type="checkbox"/> Audiology – Hearing Aid Screenings | <input type="checkbox"/> Laboratories | <input type="checkbox"/> Rehab – ST |
| | <input type="checkbox"/> Prosthetics/Orthotics | |
| | <input type="checkbox"/> Radiology/Imaging Centers | |

Address Information – Address #1

Please indicate the facility's main office, mailing, secondary, and payment address(es) by completing the appropriate information and checking one or more address type. See page 2 for additional locations.

Is this location handicap accessible? Yes No **NPI#** _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address: _____

Name _____ e-mail _____

Address Type	
(choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Primary Office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program's hours for patient care for Address #1 in the appropriate boxes:

(Examples)	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
9 – 5, or 24 hrs							

Copy this page, prior to completing, for additional offices.

Address # _____

Is this location handicap accessible? Yes No

NPI# _____

Service Types(s): _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address: _____

Name _____ e-mail _____

Address Type (choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Secondary office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program's hours for patient care for Address # _____ in the appropriate boxes:

(Examples)
9 – 5, or 24 hrs

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Address # _____

Is this location handicap accessible? Yes No

NPI# _____

Service Types(s): _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address: _____

Name _____ e-mail _____

Address Type (choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Secondary office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program's hours for patient care for Address # _____ in the appropriate boxes:

(Examples)
9 – 5, or 24 hrs

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.