

Organization Provider Demographic Information Form

Demographic / General Information

D.B.A. (signage on your door indicates) _____

Corporate name (as assigned TIN on W-9) _____

Facility tax identification number _____ Claim filing: HCFA 1500 UB

Is facility a participating Medicare provider? Yes No Medicare number _____

Is 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"/> Independent diagnostic services | <input type="checkbox"/> Radiology/imaging centers (specify) |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Pathology | <input type="checkbox"/> Diagnostic radiology |
| <input type="checkbox"/> Audiology (Specify) | <input type="checkbox"/> Prosthetics/orthotics | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Hearing aid supplier | <input type="checkbox"/> Durable medical equipment | <input type="checkbox"/> Therapeutic radiology |
| <input type="checkbox"/> Hearing screenings | <input type="checkbox"/> Prosthetics/orthotics | <input type="checkbox"/> School based health clinic |
| <input type="checkbox"/> Emergency medicine | <input type="checkbox"/> Bathroom safety bars | |

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#** _____

Specify additional service types(s) _____

Street _____

City _____

State _____ Zip code _____ County _____

Phone _____ Fax _____

Contact(s) at this address

Name email

Address type	
(choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Primary office	<input type="checkbox"/>
Payment (REMIT)	<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 completion for any additional locations.

If you have this information in another format (i.e. spreadsheet) you may provide it this way.

Address # _____

Is this location handicap accessible? Yes No

NPI# _____

Specify additional service types(s) _____

Street _____

City _____

State _____ Zip code _____ County _____

Phone _____ Fax _____

Contact(s) at this address:

Name email

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

Send completed form to:

Email: *ph-providernetworkmanagement-providerapplications@priorityhealth.com*

Fax: Attn: Provider Network Management
616 975-8851

Remember to send in your W-9 when submitting your application.