



Practice/Facility Information

Please complete a copy of this form for each location in your practice. Each section of this form must be filled out to be considered complete. If a section does not apply, please indicate with N/A.

PRACTICE/FACILITY DEMOGRAPHIC INFORMATION

Practice/Facility name:

Practice/Facility legal name (must match W-9):

Practice/Facility Specialty:

Location NPI:

Location TIN:

IMPORTANT: If practitioners at this location submit claims under more than one billing NPI and TIN combination, please include documentation of the practice billing structure and a current year copy of the W-9 for this TIN.

PRACTICE/FACILITY LOCATION INFORMATION (for provider directory)

Address:

City:

State:

Zip code:

Telephone number:

Fax number:

Office hours:

BILLING ADDRESS INFORMATION (for mailing checks and remittances)

Check if this address is the same as location address above

Address, if different than location address:

City:

State:

Zip code:

UTILIZATION MANAGEMENT (for communication on Member Authorization)

Check if this address is the same as location address above

Address, if different from location address:

City:

State:

Zip code:

Authorization fax number:

Practice/Facility website:

Please email to DataIntegrity@HealthOptions.org or fax to (207) 520.6242.