

Provider Information

Name: _____ Designation(s): _____

Office Phone: _____ Fax: _____ Cell: _____ Home: _____

Office Address: _____

Billing Address (if different): _____

Email: _____ Web: _____

What is your preferred contact method? _____

How did you hear about us? _____

Approximately how many patients do you see per week? _____

Do we have permission to submit EMC agreements on your behalf? _____

Would you like us to track co-pays/deductibles and send statements to your patients? _____

Would you like us to track and process your CAQH credentialing/attestation? _____

Would you like us to obtain and track authorizations for you? _____

Please remember that you are responsible for obtaining the initial authorization for each patient

Please list all types of insurance that you accept:

Federal Tax ID#: _____

NPI #: _____

Medicare #: _____

MaineCare #: _____

CAQH #: _____

CAQH Log-In: _____

License #: _____

DOB: _____

What are your fees for the following CPT codes:

90801: _____

90806: _____

90807: _____

90847: _____

90853: _____

90808: _____

Other: _____