NEW PRACTITIONER INFORMATION
MD, ARNP, PA, PT'S OT'S, PSYD, PHD

Provider name ____

Corporation name ____

Specialty ____

Address of office ____

____

____

Telephone # ____

Cell phone # ____

Fax # ____

Email ____

Date of birth ____

Social Security # ____

Tax ID # ____

Medical license # ____

DEA license # ____

Medicare provider # INDIVIDUAL#__________CORPORATION#_________

Medicaid provider # ____

Clia # (if any) ____

Upin # ____

BCBS# ____

NPI - INDIVIDUAL ____

NPI –CORPORATION ____