

HealthChoice

ADDITIONAL OFFICE LOCATION FORM

Name: _____
(Last) (First) (Middle) (License)

SSN: _____ NPI: _____

Primary Specialty: _____ Secondary Specialty: _____

Federal Tax ID Number: _____
(Attach a completed W-9 form for each Tax ID#)

PHYSICAL ADDRESS

Office Name: _____

Office Address: _____

(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail : _____

MAILING ADDRESS

Office Name: _____

Mailing Address: _____

(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail : _____

BILLING ADDRESS

Office Name: _____

Billing Address: _____

(City) (State) (Zip)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail : _____

Authorized Signature: _____ Date: _____

Contact Name (please print) _____ Phone: _____

RETURN FAX NUMBER (405) 717-8977