

NETWORK PROVIDER ADDITIONAL LOCATION FORM

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

NPI Number:

Primary Specialty: Secondary Specialty:

Federal Tax ID Number:

(Attach a completed Form W-9 Form for each TIN and an EFT form with a voided check or bank letter)

PHYSICAL ADDRESS

Office Name:

Office Address:

(City) (State) (ZIP)

Phone: () Fax: ()

Contact Person: Email:

MAILING ADDRESS

Office Name:

Mailing Address:

(City) (State) (ZIP)

Phone: () Fax: ()

Contact Person: Email:

BILLING NAME and ADDRESS – Billing name and address must match the claims name and address

Billing Name (must match claims):

Billing Address:

(City) (State) (ZIP)

Phone: () Fax: ()

Contact Person: Email:

Authorized Signature: Date:

Contact Name: Phone:

Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 12.2 of the provider contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents.