

HCAP USE: DB _____ INITIALS _____
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HCAP ANCILLARY - NON PHYSICIAN PROVIDER INFORMATION

EFFECTIVE DATE: _____

GENERAL INFORMATION

Provider Name	National Provider ID Number – <i>if applicable</i>
Federal Tax ID Number	License Number

LOCATION(S) – PLEASE LIST ADDRESSES AS YOU WISH THEM TO APPEAR IN DIRECTORY

Primary Site Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	
Federal Tax ID Number (if different than above)			

Secondary Site Address

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	
Federal Tax ID Number (if different than above)			

Attach a separate sheet for other locations.

Billing Remittance Address (if different than above)

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ()		Fax ()	

