PRACTICE INFORMATION FORM

Practice/Group Name_____

Person of Contact_____ Phone_____

Adress_____

Adress_____

Phone_____Fax_____

Email_____

Preference of contact_____
(Call, email, text, etc.)

Group TID_____

Group NPI_____

Individual Providers and NPI numbers

1._____

2._____

3._____

4._____

5._____

Services Needed

Medical Billing Services____ Insurance Benefits Verification_____

Prior Authorization___ Credentialing_____ Contracting_____ Consultation____

What are your immediate concerns?

_____

_____

On average, how many patients are seen at the practice? (*monthly,weekly)*_____

Top CPT Codes (List as many as you want)

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____