Diversified
HEALTH CARE MANAGEMENT

PRACTICE NAME:_____ Practice / Business Information	
Legal Practice Name:	**"DBA"**
Tax ID:	
Street Address:	**Mailing Address (if different):**
City:	**City:**
State:	**State:**
Zip:	**Zip:**
Phone:	**Fax:**
E-mail:	
Practice/Office Manager:	**Phone:** **E-mail:**
Office Contact Person:	**Phone:** **E-mail:**
Business License #: **State:**	**Effective Date:** **Expiration Date:**
CLIA #:	**Effective Date:** **Expiration Date:**
Effective Date of Incorporation/Ownership:	**Group Medicare ID:**
Group NPI:	**Group Medicaid ID:**
Please provide the following regarding Owner/Managing Contol:	**Date of Birth:**
First Name: **Middle Initial:** **Last Name:**	**City of Birth:** **State of Birth:** **Country of Birth:**
SSN:	**Medicare ID (If issued):**
NPI (If issued):	**Effective date of Ownership/Managing Control:**
Above Individual's Relationship w/Group: **(Please mark all that apply)**	**5% or Greater Direct/Indirect Owner** **Authorized Official** **Delegated Official** **Partner** **Director/Office** **Contracted Managing Employee** **Managing Employee (W-2)**

IMPORTANT: Diversified Health Care Management will not begin billing your professional charges until we have all required paperwork and provider specific identifiers on file. Please be thorough in completing all paperwork.

Please provide copies of the following:

- **CLIA License**
- **Business License(s)**
- **Certificate of Professional Liability Insurance Coverage**
- **IRS generated Documentation w/Tax ID # & Legal Name of Practice**
- **NPI Notification, User Name & Password to access**
- **Medical Record Storage Address (if different)**
- **Professional Sanctions, Criminal, Litigation, Malpractice Actions (if any)**
- **A list of current fees by CPT**
- **Name of all other practice locations outside the normal office (Hospital, Ambulatory Surgery Center.)**
- **All Insurance Carriers for which you are contracted with, including Provider ID #'s (Individual & Group)**
- **CAQH ID & Password**
- **PECOS User ID & Password**
- **Medicare Welcome Letter**
- **Voided Company Check**