Attn: MaryAnne Heath
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Practice/Group Name : ______________________________	Form Date: ____________	
Business/Vendor Name:	DBA (if appropriate):	**Business TIN:**
Physical address:		**Group NPI:**
Remittance Name:	Business Manager:	**Email address:**
Remittance Address:	Direct Phone: ( ) Clinic Phone Number: ( )	**Clinic Fax Number: ( )** **Hours of Operation:**
City, State, Zip:	Billing/Remittance Contact: Direct Phone: ( )	**Direct Fax Number: ( )**
County: Electronic Medical Record system:	EMR Application Contact:	