PROVIDER INFORMATION SHEET
PLEASE COMPLETE AND FAX TO 718-794-7808

Provider Name: ____

Provider ID Number: ____

Provider Site/ Practice Name: ____

Provider Site Locations (Address):
____

____

____

Phone & Fax #s:____

Provider Email Address:____

Provider Financial
Address:____

____

Billing Tax ID # /IRS #: ____

Individual NPI Number: ____

TAXONOMY CODE (associated with above NPI): ____________________________

CMS Certification Number (CCN) for Medicare: ____________________________

Group NPI Number: ____

TAXONOMY CODE (associated with above NPI): ____________________________