MDX Hawai'i

Office Practice Information

PROVIDER NAME: _____ _____ _____ _____
(type or print clearly) Last First Middle Degree

Are you a PCP? ☐ Yes ☐ No Specialty(ies): _____

GROUP NAME: _____
(if applicable)

PRACTICE LOCATIONS

PRIMARY PRACTICE LOCATION

Street Address _____

City, State _____ Zip Code _____

Phone Number _____ Fax Number _____

Email _____

Office Hours _____

Languages Spoken _____

Accepting New Patients? ☐ Yes ☐ No

Location Accessible to persons with disabilities? ☐ Yes ☐ No

SECONDARY PRACTICE LOCATION

Street Address _____

City, State _____ Zip Code _____

Phone Number _____ Fax Number _____

Email _____

Office Hours _____

Languages Spoken _____

Accepting New Patients? ☐ Yes ☐ No

Location Accessible to persons with disabilities? ☐ Yes ☐ No

IF MORE THAN TWO LOCATIONS, PLEASE ATTACH A SEPARATE SHEET OF PAPER WITH THE ABOVE INFORMATION

GENERAL CORRESPONDANCE ADDRESS

Practice/Provider: _____

Name: Address: _____

City/State/Zip Code: _____

CLAIMS/BILLING INFORMATION

(The information in this section will not be published)

Tax ID # (TIN): _____

NPI Number (Individual): _____ **NPI Number (Organization):** _____

Pay to Information

Group Name (if applicable): _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

Form Completed By: _____ _____
Signature Date

Print Name and Title: _____

PLEASE RETURN TO MDX HAWAII VIA:

Mail: Attn Provider Network Operations
MDX Hawai'i
500 Ala Moana Blvd, Ste. 2200
Honolulu, HI 96813

Fax: 808-532-3396
Email: ProviderOps@MDXHawaii.com