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			SECONDARY PRACTICE LOCATION		
Street Address			Street Address		
City, State	Zip Code		City, State	Zip Code	
Phone Number	Fax Number		Phone Number	Fax Number	
Email			Email		
Office Hours			Office Hours		
Languages Spoken			Languages Spoken		
Accepting New Patients?	Yes	No	Accepting New Patients?	Yes	No
Location Accessible to persons with disabilities?	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(The information in this section will not be published)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
Email: ProviderOps@MDXHawaii.com
Fax: 808-532-3396