**Beacon Health**
797 Wilson Street
Brewer, ME 04412
207.973-9799 Tele
207.989-1096 Fax

# Contact Form

Practice name: Click here to enter text. Group NPI: Click here to enter text.

Practice open to new patients? (Circle one) Yes ☐ No ☐

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Part of a larger organization? (Circle one) Yes ☐ No ☐ Name of organization: Click here to enter text.
Tax ID of organization: Click here to enter text.

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**Physical Address (location where you see patients)**

Street: Click here to enter text. Suite Click here to enter text.

City/State/Zip: Click here to enter text.

Phone #: Click here to enter text. Fax Click here to enter text.

**Mailing Address (location for correspondence)**

Street: Click here to enter text. Suite Click here to enter text.

City/State/Zip: Click here to enter text.

Phone #: Click here to enter text. Fax Click here to enter text.

**Billing Address**

Street: Click here to enter text. Suite Click here to enter text.

City/State/Zip: Click here to enter text.

Phone #: Click here to enter text. Fax Click here to enter text.

**Legal Signatory**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**CEO**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**CFO**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**Practice/Office Manager (person responsible for all operations of practice)**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**Credentialing Contact (person in their office for us to ask questions to)**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**Quality Improvement Contact (person who handles quality issues)**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**Lead Physician (for this location)**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

**Health Information Technology Contact (person knowledgeable about EMR, registry, technology related)**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

What EMR (electronic medical records) vendor do you have? Click here to enter text.

**Person providing**

Name: Click here to enter text. Title: Click here to enter text.

Email: Click here to enter text. Fax: Click here to enter text.

Phone #: Click here to enter text.

Mail to: Click here to enter text.

**This completed document should be forwarded to:**

Network Management
Beacon Health
797 Wilson Street
Brewer, ME 04412

BeaconNetMan@emhs.org

or fax to **(207) 989-1096**