

Contact Form

Practice name: _____ Group NPI: _____

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

Part of a larger organization? (Circle one) Yes No Name of organization: _____
Tax ID of organization: _____

Physical Address (location where you see patients)

Street: _____ Suite: _____

City/State/Zip: _____

Phone #: _____ Fax: _____

Mailing Address (location for correspondence)

Street: _____ Suite: _____

City/State/Zip: _____

Phone #: _____ Fax: _____

Billing Address

Street: _____ Suite: _____

City/State/Zip: _____

Phone #: _____ Fax: _____

Legal Signatory

Name: Title:

Email: Fax:

Phone #:

CEO

Name: Title:

Email: Fax:

Phone #:

CFO

Name: Title:

Email: Fax:

Phone #:

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

Name: Title:

Email: Fax:

Phone #:

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

Name: Title:

Email: Fax:

Phone #:

Quality Improvement Contact (person who handles quality issues)

Name: Title:

Email: Fax:

Phone #:

Lead Physician (for this location)

Name: Title:
Email: Fax:
Phone #:

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

Name: Title:
Email: Fax:
Phone #:

What EMR (electronic medical records) vendor do you have?

Person providing

Name: Title:
Email: Fax:
Phone #:
Mail to:

This completed document should be forwarded to:

Provider Management
Beacon Health
797 Wilson Street Brewer, ME 04412

Email to: beaconprovmgmt@emhs.org or fax
to (207) 973-7160