



Clinic Information

Complete the form thoroughly. Leave blank non-applicable and unknown information.

- Office / Clinic legal name:
 - _____
- Office / Clinic DBA name:
 - _____
- Office / Clinic incorporation date:
 - _____
- Office / Clinic street address, city, state, zip + 4:
 - _____
 - _____
 - _____
- Office / Clinic mailing address, city, state, zip + 4:
 - _____
 - _____
 - _____
- Office / Clinic phone number, fax number, e-mail address:
 - Phone: _____ Fax: _____
 - E-mail: _____

Diversified Health Care Management, Inc.

- Office / Clinic practice manager:
 - Name: _____
 - Phone: _____ E-mail: _____

- Office / Clinic contact person:
 - Name: _____
 - Phone: _____ E-mail: _____

- Office / Clinic business license number:
 - Number: _____ State: _____
 - Effective Date: _____ Expiration Date: _____

- Office / Clinic CLIA number:
 - Effective Date: _____ Expiration Date: _____

- Office / Clinic Medicare group number; Medicaid group number:
 - Medicare: _____ Medicaid: _____

- Office / Clinic Medicare submitter ID:
 - _____

- Office / Clinic Railroad Medicare submitter ID:
 - _____

- Office / Clinic Blue Cross submitter ID:
 - _____

- Office / Clinic Tax ID number – Is this a Social Security Number?:
 - _____ Yes ____ No ____

- Office / NPI number:
 - _____

Diversified Health Care Management, Inc.

- Does your office / clinic bill:
 - Medicare Claims: Yes_____ No_____
 - Medicaid Claims: Yes_____ No_____
 - Tricare Claims: Yes_____ No_____
 - U.S. Dept. of Labor claims: Yes_____ No_____
 - Railroad Medicare Claims: Yes_____ No_____
- Provider / Office / Clinic accepts VISA/Master Card Yes_____ No_____
- Number of computer workstations to access DHCM System:
 - _____
- **IMPORTANT: Attach a copy of the clinic's procedure codes price list; including the ICD-9 code, description and price.**

