Private Practice Garden LLC

Name: Maiden Names (if applicable):

SSN: DOB:

CAQH#/UserID/Password:

Professional Licensure State/Number:

Practice Name:

EIN for Practice:

DEA No. (if applicable): Supervising MD Name/Contact Ph. No. (NP only):

Individual NPI: Group NPI (if applicable):

Service Address:

Appointment Days and Hours:

Is Service Location Handicap Accessible: Unknown

Is Service location near public transportation: No

Office Phone #: Fax #:

Email address:

Billing Address:

Malpractice Insurance Provider: Billing/EHR Provider:

Website:

Languages Spoken:

Previous Practice Name/Employer:

Previous Practice/Employer NPI:

Previous Practice/Employer Tax ID:

Previous Practice/Employer Website:

Previous Practice/Employer Address:

Previous Practice/Employer Phone:

Dates at previous practice:

Professional School (Name, Full Address, Ph. No.):

Undergraduate School (Name, Full Address, Ph. No.):

Private Practice Garden LLC

Please list your active insurance panels below

Insurance Panels (Name/Original Credential Date):

1.

2.

3.

4.

Certificates (Name/Training Date/Exp Date):

1.

2.

3.

4.

Preferred Population to Serve/Issue to Treat:

1.

2.

3.

Preferred modality of Treatment:

1.

2.

References (Name/Degree/Professional Title/Phone Number/Email Address):

1.

2.

3.

Military Services (Branch/Years/Status):

Have you had licensures or certifications revoked? No

Are you prevented from billing Medicare or Medicaid? No