ADDITIONAL ORGANIZATION INFORMATION

This page is to confirm your demographic information for each additional organization (**different Federal Tax ID#**) under contract with MHC. Please make copies as needed. If you are no longer practicing at additional organizations, please inform us. Do not complete this section if you do not practice under more than one Tax ID#.

Professional Organization/Practice Name ____

(as listed on your W9 Tax Form)

Federal Tax ID#____________________________

- Primary Office

  Address____Suite_________________________

  City ______________________________ County ____________________ State ________ ZIP ____________

  ○ My primary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____________________________ext_______ Fax Number______________________________

- Secondary Practice Address *(if MHC has a secondary location on file and you do not confirm it here, we will assume you no longer see patient's at this location and will inactivate it in our database)*

  Address____Suite_________________________

  City ________________________________ County ____________________ State ________ ZIP __________

  ○ My secondary office is in my home (check if applicable)

  Handicapped Accessible ○ **Yes** ○ **No** Public Transportation ○ **Yes** ○ **No**

  Phone Number_____________________________ext_______ Fax Number______________________________

Office Manager's Name ____ Phone ext.______________

Office Manager's Email____

- Primary Mailing Address____

- Payment Address____

How do you prefer to receive information? ○ Mail ○ Email ○ Fax
(Check all that apply)

Emergency Phone Number/Procedures____

Please check all of these insurances accepted:

○ Blue Cross/Blue Shield ○ Keystone ○ Aetna
○ Cigna ○ Personal Choice