

Practice Questionnaire

Complete this form, attach the following lists and submit them with your applications for contracting in our provider network(s).

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| <ul style="list-style-type: none"> ■ list of all practice locations ■ list of the names and titles of the principal officers of the organization | <ul style="list-style-type: none"> ■ list of all health care practitioners and their professional status ■ list of the services or types of service you provide your patients or patrons (superbill) |
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General Information

Name of Practice

Service Specialty

Is the organization incorporated?
Yes No

If Yes, in which state?

What is the Employer Identification Number of the organization?
(include all numbers and hyphens)

Is any part of your practice hospital affiliated or based?
Yes No

If yes, please indicate the hospital and for what types of services:

The reimbursement to the professional members of the organization is based on (please designate):
Salary Percentage of Income Fee for Service

The services of the organization offered on the basis of (please designate):
Fee for Service Pre-Paid Other

Is the organization funded by the city, state or federal monies?
Yes No

If yes, please indicate the source of the funding and the purpose for which it is to be used (ex. Patient Care, Administration, Teaching, etc.):

Is the organization funded by any other outside group, corporation or agency? Yes No

If yes, please identify group, corporation or agency:

Mailing Address (to receive claim forms, publications and other correspondence)

Street Address

Office Telephone Number

City

State

County

Zip Code

Payment Address, if different from above (to receive reimbursement checks)

Street Address

Office Telephone Number

City

State

County

Zip Code

1099 Address, if different from above (to receive 1099 at the end of the year)

Street Address

Office Telephone Number

City

State

County

Zip Code

Authorized Signature

Name (please print)

Signature

Title

Email

Telephone Number

Date

Return the completed form to:

Mail Administrator
P.O. Box 14763
Lexington, KY 40512