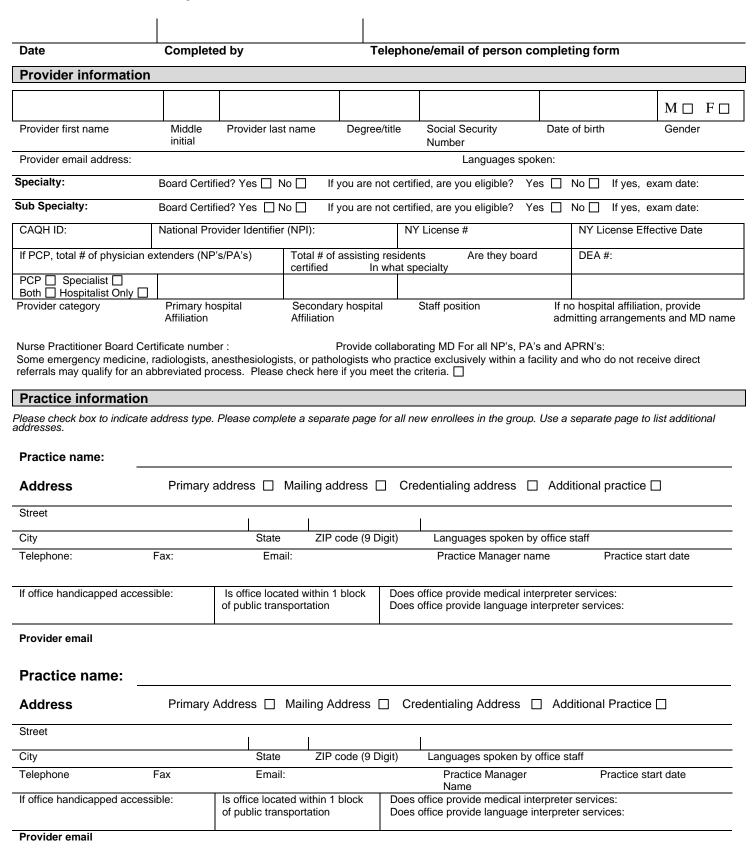
## Provider Enrollment Form

Fallon Health Weinberg-PACE



allonhealth weinberg

## **Practice Name:**

Address	Primary Address 🔲 Mailing Address 🔲 Credentialing Address 🔲 Additional Practice 🗌					
Street						
City		State	ZIP Code (9 Dig	jit) Languages	Spoken by office staf	f
Telephone:	Fax:	Email:		Practice Ma	anager Name:	Practice Start Date:
If office handicapped accessible:		Is office located within 1 block of public transportation		Does office provide medical interpreter services: Does office provide language interpreter services:		
Provider email						
			Payment Ir	formation		
Payee Name:						
Tax Identification Number         Group NPI #           Payment Address         Composition Number         Composition Number						
	Street					
City		State	ZIP Code	(9 Digit) Ema	il	
Telephone	Fax	Contact	t Name			
Optional Practice Information						
Office Hours:		<b>F</b>	1			
Monday	Tuesday	Wednesday	Thuraday	Friday	Saturday	Sundov
Monday Tuesday Wednesday Thursday Friday Saturday Sunday Average Waiting Time to Schedule:						
Initial Visit       Routine Physical       Urgent Visit         Your practice must provide 24 hour coverage. Do you have 24 hour coverage?       Yes       No         Please list Covering Providers or Group (attach additional sheet if necessary):       No       Image: Covering Provider of Cov						
Name	ering Providers	or Group (attac Specia		Provider T		Phone Number
Hame					урс	
Handicap Access: Yes No No Partnership Single Specialty Group Multi-Specialty Group Concierge Model Other:						
		Ot	her Provider	Information		
Is the provider accepting new patients?       Yes       No         Does the provider participate in and meet the conditions of participation in Medicare?       Yes       No         Does the provider have a current, valid and active Medicare participating PTAN number?       Yes       No         If yes, please indicate participating PTAN number:       Please indicate Medicaid number:       Yes       No						
Please list any p	ractice restrictior	ns for the provide	er:			
What age group	s do you treat?					
Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes □ No □						
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Information provided in this form will be utilized for the Health Plan's system configuration, as well as for mandatory provider reporting, as required by the State of New York. Providers have the right and to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Please save the completed form and submit it to: <u>AskFHW@fallonweinberg.org.</u>