

## Request to Add New Provider Instructions

Please follow the steps below to ensure that your request is processed without delay. Additionally, please also ensure the provider's CAQH application is accurate and up-to-date. **NOTE:** If there are discrepancies between this enrollment form and CAQH, the data on this enrollment form will be used. This will include differences in address details: suite number, phone number, fax number, handicap accessibility, TDD hearing, bus route, American Sign Language, and office hours.

<b>STEP 1</b> (Pages 2-4)	Application Submission	Choose either option:  1. Submit a letter or file containing all requested information on pages 2-4 of this packet. Email to enrollment@centercare.com or fax to (270) 796-3584.  2. Complete the forms on pages 2-4 in their entirety and email to enrollment@centercare.com or fax to (270) 796-3584.  Important: Failure to supply the requested information in the following pages of the Enrollment Packet will result in a processing delay.
<b>STEP 2</b> (Page 5)	Center Care Credentialing Requirements	Should the provider require credentialing for participation, please refer to page 5 for a list of required supporting documentation. Depending on the provider type, this list outlines the various documents that will be required to complete the provider's application for participation so that credentialing may be initiated. Failure to submit the required items may result in the provider's application being deemed incomplete, requiring resubmission of the provider's application. This may also result in a delay of the provider's effective date for participation.
Step 3 (Pages 6)	Behavioral Health Clinical Specialties	For Behavioral Health providers, please provide Sub Specialties from the list provided on page 6. List these Sub Specialties in the Notes Section at the bottom of the Enrollment Form on page 2.
STEP 4 (Page 7)	Kentucky Medicaid Provider ID Number	To participate in Kentucky Medicaid, an active/valid Kentucky Medicaid Provider ID Number is required. To apply for a Kentucky Medicaid Provider ID Number, see instructions on page 7.
STEP 5 (Page 8)	Sample Claim Form(s)	A sample claim form is required to ensure accurate loading of the provider. See page 8 for instructions.
STEP 6 (Page 9)	Completed W-9 Form	A W-9 form is required to prevent delays in reimbursement. See page 9 for instructions

Should you have any questions, please call us at (270) 745-1517 or (800) 972-7038.

## **Request to Add New Provider**

### Instructions

Complete this form in its entirety and submit to the contact email or fax listed in step 1 on page 1. Provider will be enrolled in commercial, Medicare, and Medicaid lines of business, as reflected in the group's contract. If participating in Medicare or Medicaid, please make sure to indicate panel status and member capacity for each address in the spaces provided below. An "open panel" will indicate a PCP provider's willingness to accept member assignment from Medicaid and Medicare managed care organizations. Panels are only applicable to PCPs.

Practice w	vebsite*:										☐ No website	
Practice e	email*:										☐ No email	
*website	and email may b	e published in	payer directo	ory								
			Provider's	Full Name (Last, Firs	st, Middle)				Degree Start D		Start Date	
I. Prov	vider Info											
Individua	II NPI #	Social Secu	rity Number	Date of Birth		Medica	are Numbe	er Medic	aid Number		CAQH ID#	
							☐ pei	nding	☐ pendi	ing		
Primary S	Specialty			Secondary Spe	cialty				ages Spoken	Ü	☐ English Only	
Primary 1	Гахопоту			Secondary Tax	onomy			Group	Taxonomy			
Name of	Supervising/Coll	laborating Ph	ysician (NP, F	PA)		Super	vising/Coll	aborating Ph	ysician's Spec	cialty	<i>y</i>	
Primary H	Hospital Affiliation	n (MD, DO, DPI	M, DMD, NP, P	A)		City, S	tate			Aff	filiation Status	
For provi	ders without act	ive hospital p	rivileges, ple	ease indicate eithe	er your Ad	mitting /	Arrangeme	ent or request	to waive requ	iirem	nent (select one):	
	Admitting Physi	ician or Hospita	alist Group na	name:								
		-		r hospitalist group:								
	I do not have ho	ospital privilege	es or an admi	tting arrangement o	due to my s	cope of p	oractice and	d request this	requirement be	waiv	red.	
II. Cor	ntact Info											
Credentiali	ing Contact Name		P	hone #	E-mail							
Credentiali	ing Correspondend	ce Address 1	A	ddress 2			City		State	•	Zip	
			_		<b>-</b>							
Practice Co	ontact Name		Р	hone #	Fax #			E-mail				
		☐ Same	e as above						,			
Practice Co	orrespondence Ad	dress 1	A	ddress 2			City		State	)	Zip	
		□ Same	e as above									
Notes: Ple	ease include any add			cessing this request								

**III. Primary Address Information.** Primary address will be listed in directory as long as provider is at location 16 hours or more (unless opted <u>out</u> of directory below). Covering sites will not be listed in directory. If provider practices at more than one location, please complete section IV. Additional Locations.

Address Type	Tax I	D#			Gre	oup N	lame (inc	lude DBA)						
☐ Primary Office	•													
☐ Covering Only	/													
Scope of Praction	ce for this site				Ad	dress	i 1	Addre	ess 2 (suite	e)				
☐ Primary Care [	☐ RHC ☐ Ur	gent Care	☐ Inpatien	t Care										
☐ Specialty Care	□ w:	alk-in Care	e 🗆 Emerge	ncy Care										
If specialty care	, please design	ate prac	tice specialty		Cit	y, Sta	ite, Zip			[	☐ Dir Opt	t- <b>OUT</b> for thi	s loca	ition
CLIA Number		CLIA E	Expiration		Group NPI				Phone #		Fax #			
Location-Specif	ic Information				Υ	N							Υ	N
Does practice offer lab services at this site? (CLIA Required)						Is addre	ess handicap	accessible?						
Is provider at this	site at least 16	hours pe	r week?				Is addre	ess TDD hea	ring equipped?					
Can patients call	this site to make	appoint	ment with prov	rider?					le by bus route?					
Is provider accep									de American Sign La	nguage ser	vices at t	this site?		 
Is provider a PCF							Does pr	ovider provi	de telemedicine servi	ces at this	site?			
Does provider pro	ovide EPSDT se	rvices at	this site?						r DME services? (P			1)		 
If PCP, is provide				>			Does th	is site partic	ipate in KHIE?			,		 
If PCP, is provide									tenens provider?					
What is the maxis									eted cultural compete	ence training	g?			
What is the maxing	mum panel capa	city for M	ledicare at this	s site?										
What are the age	limitations for p	atients se	een by provide	r?										
Is there a gender	restriction at thi	s site? (If	yes, please spe	cify)										
Is there a gender restriction at this site? (If yes, please specify)				Tuesda	21/		Wedne	sdav	Thursday	Friday		Saturda	av	
			i uesuc	ay	ay Would									
Office Hours	Sulluay	WOI	iuay	ruesua	ау		Trouis.	- · · · · <b>,</b>					<b>-</b> y	
	·		iday	Tuesua	ау		Tround				Fax #		- 7	
Office Hours Pay To Name (i.e.	·		iudy	ruesua	ay				Phone #		Fax #		-,	
	·		iday	ruesua	ау						Fax #			
	e., billing name		May	Tuesua	ay			City		State				
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Pay To Name (i.e.	e., billing name		□ Same as S			ponder				State	e Z			
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Pay To Name (i.e.	e., billing name					oonder		City		State	e Z	Žip		
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Pay To Name (i.e. Pay To Address  Correspondence	e., billing name					ponder		City		State	e Z	Žip		

#### IV. Additional Locations

Please list alternate and covering-only locations below. Primary address should be listed on the prior page of this packet. Please make additional copies of this sheet, if more than two addresses are required.

**Alternate Office Sites** – Secondary sites where patients can call to make appointment to be seen by physician. If patients cannot make appointments with provider at this location, please designate location as "Covering only."

**Covering-only Sites** — Other sites that are to be loaded only for the times when provider covers for another provider or sites where provider does not accept appointments regularly. Patients cannot schedule appointment with provider at covering locations.

"Pay To" Name – This should match exactly how the claims are submitted from your billing system to insurance carriers, including abbreviations.

**Additional Address.** Alternate sites will only be listed in directory if provider is at location 16 hours or more, (unless opted <u>IN</u> to directory to override). If opting IN to directory, provider MUST accept appointments at that location. Covering sites will not be listed in directory. Please make copies of this page for additional sites.

Address Type Tax ID#				Group Name (include DBA)												
☐ Alternate Offi	☐ Alternate Office															
☐ Covering Onl	у															
Scope of Practi	ce for this	site			Address 1							Address 2 (suite)				
☐ Primary Care	RHC	☐ Urgent Care	☐ Inpatier	nt Care												
☐ Specialty Care ☐ Walk-in Care ☐ Emergency Care																
If specialty care, please designate practice specialty				Cit	ty, St	ate, Zip					☐ Dir O	pt- <mark>IN</mark> for thi	is loca	ation		
CLIA Number		CLIA E	xpiration		Gr	oup l	NPI		Phone #		F	ax #				
			•													
Location-Specif	fic Informa	tion			Υ	N								Υ	N	
Does practice of			? (CLIA Requ	uired)			Is addre	ess handica	p accessible?							
Is provider at this	s site at lea	st 16 hours pe	r week?				Is addre	ess TDD he	aring equipped?							
Can patients call	I this site to	make appoint	ment with pro	vider?			Is addre	ess accessil	ole by bus route?							
Is provider accep	oting new pa	atients at this	site?				Does p	ractice provi	ide American Sign L	anguag	e serv	ices at tl	nis site?			
Is provider a PCI	P at this site	e?					Does p	rovider prov	ide telemedicine sei	vices?						
Does provider pr	ovide EPSI	DT services at	this site?				Does p	rovider bill fo	or DME services?	Provide	samp	le claim)	)			
If PCP, is provide	er's panel o	pen at this site	for Medicaid	l?			Does th	is site partio	cipate in KHIE?							
If PCP, is provide	er's panel o	pen at this site	for Medicare	?			Is provi	der a locum	tenens provider?							
What is the maxi	imum panel	capacity for M	ledicaid at thi	is site?			Has pro	vider comp	leted cultural compe	tence tr	aining	?				
What is the maxi	imum panel	capacity for M	ledicare at th	is site?												
What are the age	e limitations	for patients s	en by provid	er?												
Is there a gende	r restriction	at this site? (If	yes, please sp	ecify)												
	Sunday	Mon	day	Tuesday	′		Wedne	sday	Thursday Friday		ay	y Saturd		ay		
Office Hours																
Pay To Name (i.	e hilling r	name)							Phone #		F	ax #				
ray ro rame (i.	ici, billing i	iuiio)							T Hone w			ux II				
Pay To Address	3							City			State	Zij	<b>o</b>			
Correspondenc	e Address	3	☐ Same as	Section II Co	rresp	onden	се	City			State	Zij	<b>o</b>			
Notes																

## **Center Care Credentialing**

### **IMPORTANT NOTES:**

This list has been prepared to assist you in providing the most commonly required documentation needed for the provider to be credentialed. Failure to submit the required items may result in the provider's application being deemed incomplete, requiring resubmission of the provider's application. This may also result in a delay of the provider's effective date for participation, resulting in a delay in reimbursement.

### Notification of Practitioner Rights

Please be advised that applicants for credentialing or recredentialing have the right to (1) review information submitted to support his/her credentialing application, (2) correct erroneous information, and (3) be informed of his/her credentialing or recredentialing application, upon request.

ITEM	ADDITIONAL INFORMATION
COMPLETED CAQH APPLICATION	<ul> <li>CAQH application "Last Attestation Date" cannot be more than 60 days old.</li> <li>CAQH application should be updated to reflect the practice location(s) and relevant information for which we are to credential the provider. Attach applicable supporting documents in CAQH.</li> </ul>
	<ul> <li>"Standard Authorization, Attestation and Release" page should be included in CAQH, signed and dated, and signature to match provider's legal name.</li> </ul>
	Required for MD, DO, DPM, DMD. Exception for Radiologists and Pathologists.  Provided to ARRAN (ARRAN STATE OF ARRAN STAT
DEA CERTIFICATE	<ul> <li>Required for APRNs, if APRN writes/dispenses/prescribes controlled substances.</li> <li>If provider will be practicing in more than one state, DEA required for each applicable state.</li> </ul>
	If provider does not have a DEA or the DEA is pending, written explanation or documentation of coverage arrangements is needed (e.g. another practitioner will write all prescriptions on his/her behalf).
STATE LICENSURE	CAQH Section 1 to indicate state license number and a copy of the provider's license to be attached.  If provider will be providing in more than one otate license required for each applicable state.
	If provider will be practicing in more than one state, license required for each applicable state.
EDUCATION AND TRAINING	<ul> <li>CAQH Section 2 (or CV/resume) to indicate Professional/Medical School, start and end dates (month/year).</li> <li>Required for MD, DO, DPM, DMD. CAQH Section 2 (or CV/resume) to indicate Training programs, start and end dates (month/year).</li> </ul>
BOARD	Required for MD, DO, DPM, DMD; excludes General Practitioners.
CERTIFICATION	CAQH Section 3 should indicate if the provider is board certified in their specialty.
OFFICE HOURS/ ACCESSIBILITIES	CAQH Section 4 to indicate Office Hours, Handicapped Access, TDD Hearing (text telephony), American Sign Language, and Accessible by Bus. If laboratory services are provided, attach CLIA certificate.
HOSPITAL PRIVILEGES	<ul> <li>Required for MD, DO, DPM, DMD, PA, APRN. May be waived for Telemedicine and Urgent Care Providers.</li> <li>Exceptions may be considered for Radiologists, Dermatologists, Pathologists and Anesthesiologists.</li> <li>CAQH Section 5 should indicate Hospital Privileges or Admitting Arrangements.</li> </ul>
	<ul> <li>A current copy of the Certificate of Insurance to be attached; must reflect malpractice limits of \$1M/\$3M, provider's name, and effective/expiration dates.</li> </ul>
CERTIFICATE OF	<ul> <li>Limits of \$1M/\$1M are acceptable for ABA, AUD, BC-ADM, CDE, CFA, CSA, LCADC, LCSW, LMFT, LPAT, LPCC, LPP, OT, PT, RD, and SLP. For Indiana providers only, \$500K/\$1.5M is acceptable.</li> </ul>
INSURANCE	If provider will be practicing in more than one state, confirm whether the policy covers all applicable states.
	• If provider's name is not on the certificate, a copy of the roster or documentation that provider is covered under the group's policy is needed.
WORK HISTORY	CAQH Section 7 (or CV/resume) to indicate complete work history (month/year) since highest level of education/training or last 5 years. If any gaps 6 months or longer, explanation is required.
SUPERVISING/ COLLABORATING PHYSICIAN	Required for PA, APRN. The supervising/collaborating physician's name and specialty are to be indicated.

## **Behavioral Health Clinical Specialties Codes and Descriptions**

Code	Description	Code	Description
AA	ADD/ADHD Counseling	DR	General Depression Counseling
AD	Addictionology (MD's Only)	GR	Grief and Loss Counseling
Al	Adoption Counseling	GT	Group Therapy
AF	AIDS/HIV Counseling	HV	Home-Based Behavioral Health Services
AC	Alcohol and Substance Use Counseling (certified)	LD	Learning Disabilities
AS	Alcohol and Substance Use Counseling (self-reported)	ML	Medical Illness Counseling
AM	Anger Management Counseling	MC	Marriage/Couples Counseling
AE	Appointments Available in the Evening	BS	Medication Assisted Treatment (MAT) for Substance Use: Buprenorphine/Suboxone
AW	Appointments Available on the Weekends	MV	Medication Assisted Treatment (MAT) for Substance Use: Vivitrol
AB	Autism Applied Behavioral Analysis (ABA)	МО	Menopause Counseling
AG	Autism Social Skills Training	MI	Men's Counseling
AT	Autism Testing	DD	Mental Health and Substance Use Counseling (Dual Diagnosis)
AR	Autism Treatment	NT	Neuropsychological Testing (Psychologists Only)
BP	Behavioral Pediatrics (MD)	ОС	Obsessive Compulsive Disorder (OCD) Counseling
BF	Biofeedback Counseling	PM	Pain Management
BD	Bipolar Disorder (Manic Depression) Counseling	PA	Panic Disorder Counseling
BR	Borderline Personality Disorder (BPD) Counseling	PH	Phobias Counseling
CD	Conduct/Disruptive Behavior Therapy Counseling	MH	Postpartum Depression Counseling
CE	Cultural/Ethnic Counseling	PT	Post-Traumatic Stress Disorder (PTSD) Counseling
DL	Developmental Disorders Counseling	MJ	Psychiatric Medication Management: Injectable Meds
DB	Dialectical Behavior Therapy	MM	Psychiatric Medication Management: Oral Meds
DS	Dissociative Disorder (Multiple Personalities) Counseling	PS	Psychological Testing
DV	Domestic Violence Counseling	PD	Psychotic Disorders
RF	EAP: Assessment/Referral	SI	Sexual Abuse Counseling
ED	Eating Disorders Counseling	SD	Sexual Health Counseling
EC	Eye Movement Desensitization and Reprocessing (EMDR)	SO	Sexual Offender Counseling
CC	Faith-Based Counseling: Christian	GL	Sexual Orientation Counseling
FB	Faith-Based Counseling: Other than Christian Only	TM	Transcranial Magnetic Stimulation (TMS)
FY	Family Counseling	TH	Virtual Counseling Provided (via video)
FI	Fertility Counseling	TO	Virtual Counseling Only (via video)
FR	First Responder Counseling	WI	Women's Counseling
GA	Gambling Counseling		
GI	Gender Identity Counseling		
AX	General Anxiety Counseling		

# Instructions for a Provider on How to Apply for a Kentucky Medicaid ID Number

Please follow the link below to Kentucky's Department for Medicaid Services' website for instructions to enroll as a new Kentucky Medicaid provider:

https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx

## Sample Claim Form (SCF) Instructions

## **HCFA 1500 CLAIM FORM:**

A Sample HCFA 1500 Claim Form is required to ensure accurate loading of demographics. Please refer to below information:

- 1. The following sections of the sample claim form must be completed (all other areas are optional, and no PHI should be provided):
  - a. Box 24j = This is where the NPI # must be entered.
  - b. Box 25 = Federal Tax Identification #
  - c. Box 31 = Rendering Provider's Name (degree is optional; name should be legal name)
  - d. Box 32 = Service Location of where services were rendered. In most cases, this address should match the address that is being given as the Provider's Primary Address, or Alternate Location.
  - e. Box 33 = The Provider's Pay To Address.

NOTE: A copy of your Professional 837p is an acceptable alternative to a HCFA 1500:

- i. Bill to Loop 2010AA Provider qualifier '85'
- ii. Rendering Loop 2310B Provider qualifier '82'
- iii. Service Facility Loop 2310D or Loop 2420C qualifier '77' or 'FA'

IMPORTANT: Information in Box 33 of Sample Claim MUST match the pay-to information that is being billed electronically. Please double check this field to ensure that the PAY-TO information is reflected and not the BILL-TO.

### **UB04 CLAIM FORM:**

A Sample UB04 Claim Form is required for Institutional Providers (i.e. Hospitals, Distinct Part Unit Psychiatric, Distinct Part Unit Rehabilitation, Home Health, etc.).

- 2. Sample Form UB04 is required for Institutional Providers:
  - a. Box 1 = Physical Location
  - b. Box 2 = Billing Address (if different)
  - c. Box 5 = Vendor TIN
  - d. Box 56 = NPI #

NOTE: A copy of your Institutional 837I is an acceptable alternative to a UB04:

- i. Bill To Loop 2010AA Provider qualifier '85'
- ii. Pay To Loop 2010AB Provider qualifier '87'
- iii. Service Facility 2310E qualifier 'FA'

## W-9 Helpful Guidelines

At the request of the payers accessing Center Care's network, Center Care is required to collect a W-9 for every Tax Identification Number (TIN) in the network.

## The W-9 must be the most current form version available from the IRS.

Please note the following to ensure your W-9 is accurate:

- 1. The purpose of a W-9 is to inform Payers the name and address your TIN is registered under with the IRS. If you are not sure what this is, please reference a recent document sent to you by the IRS.
- 2. When completing your W-9 Form:
  - a. Line 1 of the W-9 is Mandatory.
  - b. Line 2 of the W-9 is Optional (DBA).
  - c. The address on the W-9 can, but is NOT required, to match the billing address. Again, the W-9 address should be what the IRS has on file for the TIN, which may or may not be the same as your billing address.
  - d. Please ensure your W-9 matches EXACTLY the way the IRS has your name and address listed, including abbreviations (St vs. Saint, Rd vs. Road, Ste vs. Suite, etc.).
  - e. The W-9 must be signed and dated.
- 3. Should your W-9 name or address change, please submit an updated W-9 along with the names of all affected providers to be updated.

Please ensure your W-9 accurately reflects the information the IRS has on file for your TIN to prevent potential delays in reimbursement.

## **APPENDIX**

**Additional Addresses.** If Pay To and Correspondence Information are NOT the same as that of the Primary Address, please make copies of page 4 to include this information. If more than 4 addresses are required, please make additional copies of either this page or page 4, as appropriate.

Address Type	Tax ID#			Gre	oup l	Name (include DBA)								
☐ Alternate Office														
☐ Covering Only									Т					
Scope of Practice				Ad	Address 1 Address 2 (su									
☐ Primary Care ☐		_ '												
☐ Specialty Care	☐ Walk		ency Care											
If specialty care, p	lease designat	e practice special	ty	Cit	City, State, Zip ☐ Dir Opt-IN for this loca									
CLIA Number		CLIA Expiration		Gre	oup I	NPI	Phone #		Fax #					
Location-Specific	Information			Υ	N						Υ	N		
Does practice offer		his site? (CLIA Red	quired)			Is address handicar	accessible?							
Is provider at this site at least 16 hours per week?						Is address TDD hea	aring equipped?							
Can patients call this site to make appointment with provider?						Is address accessib								
Is provider accepting						Does practice provi	de American Sign La	nguage se	ervices at th	his site?				
Is provider a PCP a							de telemedicine servi							
Does provider provi	ide EPSDT serv	ices at this site?				Does provider bill fo	or DME services? (P	rovide sa	mple claim)	)				
If PCP, is provider's	s panel open at t	his site for Medicai	d?			Does this site partic	ipate in KHIE?							
If PCP, is provider's	s panel open at t	his site for Medicar	e?			Is provider a locum	tenens provider?							
What is the maximu	ım panel capaci	ty for Medicaid at th	nis site?			What are the age lir	mitations for patients	seen by p	rovider?					
What is the maximu	ım panel capaci	ty for Medicare at the	nis site?			Is there a gender re	striction at this site?	If yes, plea	se specify)					
Is the Pay To addre	ess the same as	that of the primary	address?			Is the Correspondence	address the same as the	at of the pr	imary addre	ss?				
S	unday	Monday	Tuesday	'		Wednesday	Thursday	Friday		Saturda	ıy			
Office Hours														
Address Type	Tax ID#			Gre	oup l	Name (include DBA)								
☐ Alternate Office	Tax ID#			Gre	oup l	Name (include DBA)								
☐ Alternate Office ☐ Covering Only					-									
☐ Alternate Office ☐ Covering Only Scope of Practice	for this site				oup I				Address	2 (suite)				
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐	for this site	nt Care ☐ Inpatie			-				Address	2 (suite)				
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐ Specialty Care	for this site  RHC Urger	nt Care ☐ Inpatie	ency Care	Ad	dres	s 1								
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐	for this site  RHC Urger	nt Care ☐ Inpatie	ency Care	Ad	dres					2 (suite)		ition		
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐ Specialty Care	for this site  RHC Urger	nt Care ☐ Inpatie	ency Care	Ad	dres	s 1						ation		
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐ Specialty Care  If specialty care, p	for this site  RHC Urger  Walk-  Ulease designate	nt Care	ency Care	Ad	dres	s 1 ate, Zip	Phone #		☐ Dir O			ation		
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐ Specialty Care	for this site  RHC Urger  Walk-  Ulease designate	nt Care ☐ Inpatie	ency Care	Ad	dres	s 1 ate, Zip	Phone #					ation		
☐ Alternate Office ☐ Covering Only Scope of Practice ☐ Primary Care ☐ Specialty Care If specialty care, p	for this site  RHC Urger  Walk- please designat	nt Care	ency Care	Ad Cit	dres y, St	s 1 ate, Zip	Phone #		☐ Dir O		is loca			
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