Section 2

Office/Practice Information: If more than one office, **please complete section 2 for each additional office.**

Tax ID No. TaxIDwheresrvcarerender Is the Tax ID No. incorporated? ☐ Yes ☐ No

Office Type: ☐ Primary ☐ Secondary Are you currently practicing at this address? ■ Yes ☐ No

If yes, indicate your practice start date. If no, indicate your expected start date: ____ / ____ / ____ (MM / DD / YYYY)

Practice Type Pharmacist Group/Pharmacy Taxonomy Code 183500000X

Practice NPI NPIwheresrvcarere NPI Type: ■ Organization ☐ Subpart ☐ Individual Taxonomy Code ____

Suppress office/practice from directory? ☐ Yes ☐ No Practice name to appear in directory Name you want in the directory

Corporation name as it appears on W-9 (if different than above) Business name i.e Pharmacy(who will get payment)

Corporation owner(s), partner(s), and or investor(s) ____
(Attach additional pages if necessary)

Location Address Location where pharmacist will render services
Street

City State ZIP

Location Phone No. ____ Fax No. ____

Office E-mail Address ____

Providers Appointment Phone No. ____ (if different than location phone no.) After-Hours Emergency Phone No. ____

Contact Name General contact for business Phone No. ____ Fax No. ____

Contact Position/Title ____ Contact E-mail Address ____

Correspondence Address Mailing Address
Street

City State ZIP

Correspondence Phone No. ____ Fax No. ____

Contact Name General contact for business Phone No. ____ Fax No. ____

Contact Position/Title ____ Contact E-mail Address ____

Billing/Payment/Remittance Address Where payments are mailed
Street

City State ZIP

Billing Phone No. ____ Fax No. ____

Contact Name General contact for billing Phone No. ____ Fax No. ____

Contact Position/Title ____ Contact E-mail Address ____

Check payable to (should be consistent with your W-9) Business name i.e Pharmacy(who will get payment)

Accessibilities:

Does this site meet ADA accessibility requirements? ☐ Yes ☐ No

Does this site offer the following services to the disabled?

Text telephone (TTY) ☐ Yes ☐ No TTY Phone No. ____

Sign language ☐ Yes ☐ No Mental/physical impairment services ☐ Yes ☐ No

Business Operations:

Does this practice file claims electronically? ☐ Yes ☐ No

If yes, indicate the name of the clearing house or method with which your practice submits claims electonically

Please continue on next page.→

Section 2 (cont'd)

Does this practice employ a billing service? ☐ Yes ☐ No If yes, complete the Business Associate Form (form #15-803).

Services Performed in the Office: Please check all that apply:

☐ EKG	☐ Office gynecology (routine pelvic/PAP)	☐ Age appropriate immunizations	☐ Drawing blood
☐ X-rays	☐ Tympanometry/audiometry screening	☐ Flexible sigmoidoscopy	☐ Minor surgery
☐ Laceration repair	☐ Pulmonary function studies	☐ Asthma treatment	☐ Allergy skin testing
☐ Radiology services	☐ Osteopathic manipulation	☐ IV hydration/treatment	☐ Allergy injections
☐ Lab	☐ Cardiac screening test	☐ Physical therapy	

☐ Other (please specify) _____

Mid-Level Practitioners:

Do mid-level practitioners **(APRN or PA)** care for patients in your office? ☐ Yes ☐ No

If yes, please list the APRN/PA and their collaborating/supervising physician below:

_____ _____
Name Collaborating/Supervising Physician

_____ _____
Name Collaborating/Supervising Physician

PAs practicing at a different location than their supervising physician must also answer the following questions:

1. Has the PA spent a minimum of 80 hours, since being licensed, under the physical supervision and direction of a physician licensed in Kansas? ☐ Yes ☐ No
2. Does the PA's supervising physician, actively licensed in KS, periodically see and treat patients at the different location? ☐ Yes ☐ No
3. Is written notice conspicuously posted stating the practice location is staffed primarily by a physician assistant? ☐ Yes ☐ No

Practice Office Hours: Provide regular office hours **applicable to the office/practice at this location**

	Open		Close		Open		Close
Monday	_____	to	_____	Friday	_____	to	_____
Tuesday	_____	to	_____	Saturday	_____	to	_____
Wednesday	_____	to	_____	Sunday	_____	to	_____
Thursday	_____	to	_____				

Provider Office Hours: Provide regular office hours **applicable to the provider at this location** if different than above

	Open		Close		Open		Close
Monday	_____	to	_____	Friday	_____	to	_____
Tuesday	_____	to	_____	Saturday	_____	to	_____
Wednesday	_____	to	_____	Sunday	_____	to	_____
Thursday	_____	to	_____				

Providers Practice Restrictions:

Accept new patients into this practice? ☐ Yes ☐ No Accept all new patients? ☐ Yes ☐ No

Are there any practice limitations?	Gender limitations?	Age limitations?	List other limitations:
☐ Yes ☐ No	☐ Male only ☐ Female only ☐ None	____ Minimum age Maximum age	

Authorization: I hearby affirm the information submitted in this form to be true, current, correct and complete to the best of my knowledge and belief and furnished in good faith.

Name Person completing form _____ Contact Position/Title _____
First, Last

Your signature required

_____ **Date** ____/____/____
Signature of Provider/Legal Designee

CLEAR DATA