WPPA, INC. PROVIDRS CARE

PROVIDER DEMOGRAPHICS

Please submit a separate form for each Tax ID#. Sections I-II *MUST* be completed to ensure proper payment. Attach additional pages as needed.

TAX ID #:	**DATE:**
MEDICARE PTAN *facility and ancillary service providers only*:	

SECTION I: PAYMENT APPENDICES *check all applicable services that are rendered under Tax ID # listed above*

Facility:

- ☐ Critical Access Hospital (CAH) Method I Billing With Swing Bed
- ☐ Critical Access Hospital (CAH) Method II Billing With Swing Bed
- ☐ Critical Access Hospital (CAH) Method I Billing Without Swing Bed
- ☐ Critical Access Hospital (CAH) Method II Billing Without Swing Bed
- ☐ Hospital
- ☐ Skilled Nursing Facility (SNF)
- ☐ Surgery Center

Ancillary:

- ☐ Durable Medical Equipment
- ☐ Home Infusion
- ☐ Home Health Care
- ☐ Dialysis Center
- ☐ Transportation
- ☐ Orthotic & Prosthetic Supplier
- ☐ Laboratory
- ☐ Hospice
- ☐ Public Health

Provider Group / Clinic:

- ☐ Clinic/Urgent Care Clinic
- ☐ Federally Qualified Health Clinic (FQHC)
- ☐ Anesthesiology Group
- ☐ Convenience Care Clinic
- ☐ Rural Health Clinic (RHC)

SECTION II: PRIMARY PHYSICAL LOCATION *check if same as mailing address*

Facility/Organization Name			
Street Address	City	State	Zip Code + 4
Phone Number	Fax Number	NPI Number	
Website Address			

Does this site comply with the American Disabilities Act (ADA) including parking, entryways & other relevant space? ☐ Y ☐ N	Is this Location a Federally Qualified Health Clinic? ☐ Y ☐ N
Does this site comply with the American Disabilities Act (ADA) and have exam rooms that are accessible for people with disabilities? ☐ Y ☐ N	Is this Location a Rural Health Clinic? ☐ Y ☐ N
Does this site comply with the American Disabilities Act (ADA) and have equipment accessible for people with disabilities? ☐ Y ☐ N	Date of most recent Cultural Competency Training: (mm/dd/yy)

CONTACT PERSON

Name/Title	E-mail Address
Phone Number	Fax Number

Clear Form

PROVIDER DEMOGRAPHICS

SECTION III: ADDITIONAL LOCATION *check all that apply:*	Practice	Mailing	N/A
Facility/Organization Name			
Street Address	City	State	Zip Code + 4
Phone Number	Fax Number	NPI Number	
Website Address			
Does this site comply with the American Disabilities Act (ADA) including parking, entryways & other relevant space? ☐Y ☐N	Is this Location a Federally Qualified Health Clinic? ☐Y ☐N		
Does this site comply with the American Disabilities Act (ADA) and have exam rooms that are accessible for people with disabilities? ☐Y ☐N	Is this Location a Rural Health Clinic? ☐Y ☐N		
Does this site comply with the American Disabilities Act (ADA) and have equipment accessible for people with disabilities? ☐Y ☐N	Date of most recent Cultural Competency Training: (mm/dd/yy)		
CONTACT PERSON *check if same as Section II* ☐			
Name/Title	E-mail Address		
Phone Number	Fax Number		

SECTION IV: ADDITIONAL LOCATION *check all that apply:*	Practice	Mailing	N/A
Facility/Organization Name			
Street Address	City	State	Zip Code + 4
Phone Number	Fax Number	NPI Number	
Website Address			
Does this site comply with the American Disabilities Act (ADA) including parking, entryways & other relevant space? ☐Y ☐N	Is this Location a Federally Qualified Health Clinic? ☐Y ☐N		
Does this site comply with the American Disabilities Act (ADA) and have exam rooms that are accessible for people with disabilities? ☐Y ☐N	Is this Location a Rural Health Clinic? ☐Y ☐N		
Does this site comply with the American Disabilities Act (ADA) and have equipment accessible for people with disabilities? ☐Y ☐N	Date of most recent Cultural Competency Training: (mm/dd/yy)		
CONTACT PERSON *check if same as Section II* ☐			
Name/Title	E-mail Address		
Phone Number	Fax Number		

Please submit completed form to:

Email: Contracting@ProviDRsCare.Net

Mail: **ProviDRs Care Contracting**
1102 S. Hillside
Wichita, KS 67211