



**CRESCENT**

HEALTH SOLUTIONS

## Provider Demographic Sheet

*Please complete the information below so that we can list the specifics of your practice correctly on our website and in any employer directories that we may print.*

<b>Practice Name:</b>	
<b>Tax Identification #:</b>	
<b>Practice NPI #:</b> <i>(If multiple locations please include each applicable ID#)</i>	
<b>Physical Address:</b> <i>(Include multiple locations. If separate tax id numbers, please complete a separate form)</i>	
<b>Remittance Address:</b> <b>Telephone#:</b> <b>Contact Name:</b>	
<b>Mailing Address:</b>	
<b>Telephone #:</b>	
<b>Fax #:</b>	
<b>Office Manager:</b> <b>Address:</b>  <b>Telephone#:</b> <b>Email Address:</b>	
<b>Credentialing Contact:</b> <b>Address:</b>  <b>Telephone #:</b> <b>Email Address:</b>	
<b>Managed Care Negotiations Contact:</b>  <b>Address:</b>  <b>Telephone #:</b> <b>Email Address:</b>	



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**Please list all providers that are included in your practice, their individual NPI and Medicare numbers, and the locations in which they provide service. Please make a copy to use if more space is needed.**

PRACTICE **BILLING NAME ON CLAIMS:** \_\_\_\_\_

Provider Name & Location (s)	Provider Name on Billed Claims	Individual NPI#	Medicare ID#