RCIPA
Rochester Community Individual Practice Association, Inc.

RCIPA Healthcare Provider information Sheet
Email to rcipainfo@rcipa.com or fax to 585-287-9982
For Assistance www.rcipacontact.com

Provider Effective Date (the date the provider started with the practice) _____

Provider Type (please circle) ☞ **Community-based provider** **Hospital-based Provider**
A hospital-based provider is defined as a provider that only sees patients as a result of their being admitted or directed to the hospital

If Hospital-based provider (please circle type of hospital-based provider)
Hospitalist **Emergency/Observation** **Pathologist** **Radiologist** **Anesthesiologist** **Other**_____

/ /

⇧ **Provider Name** (last / first / middle) *please print*

⇧ **Date of Birth** (mm/dd/yyyy)	**M F** ⇧ **Gender** (please circle)	⇧ **Title** (MD, PhD, etc.)

⇧ **Individual NPI** (10 digits)	⇧ **NY State License** (6 digits)	⇧ **Lic. Expire Date** (mm/yyyy)	⇧ **CAQH PIN** (8 digits)

⇧ **DEA Certification #**	⇧ **DEA Expiration Date** (mm/dd/yyyy)	⇧ **Provider Contact Email**

⇧ **Primary Specialty**	⇧ **Certifying Board if board certified else NA**

⇧ **Other Specialty** (if applicable)	⇧ **Certifying Board if board certified else NA**

⇧ **Malpractice Carrier Name**	⇧ **Policy Number**	⇧ **Occurrence / Aggregate)**	⇧ **Begin/End Dates**

⇧ **Primary Hospital Affiliation**	**Yes No** ⇧ **Admitting Privileges** (please circle)	⇧ **Effective Date** (mm/dd/yyyy)

⇧ **Billing TIN (tax id # 9 digits)**	⇧ **Legal (W9) Taxname**	⇧ **DBA**

⇧ **Billing Address** (street, city, state, zip code)	⇧ **Billing Telephone #**

⇧ **Practice Address** (street, city, state, zip code	⇧ **Practice Telephone #**

⇧ **Practice Department or Group Name** (e.g. Dept. of Pediatrics, ABC Physical Therapy)	⇧ **Practice Fax #**

*if additional practice locations are required please include on a separate page.