

# Provider Personal Information

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Provider Name:

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Date of Birth:

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SSN#

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Provider Specialty:

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Provider NPI:

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Practice Joining Date:

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Provider Phone#

# Practice Information

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Name: ­­Group/Single:

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Tax ID# NPI:

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Medicare PTAN: CLIA:

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Practice Servicing Address:

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Practice Mailing address:

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Office Manager Name:

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Office Manager Phone#

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Practice Phone# Practice Fax:

# Billing Collection Details

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Using EHR/EMR:

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Clearing House:

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Monthly Reimbursement:

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Monthly New Charge Volume:

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Total Account Receivable:

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90+ Collectibles:

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Major Payer:

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Facing Denial Ratio:

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Common Denial facing if any:

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Practice main concern if any: