PODIATRY BILLING SERVICES

CONFIDENTIAL CLIENT INFORMATION

Legal Name of Practice (As per IRS or Social Security) _____

Federal Tax ID #: _____ email address: _____

Practice Type: ___ Solo ___ Group ___ LLC ___ PA ___ PC ___ S-Corp ___ C-Corp

Please list ANY insurance company that uses a Social Security Number in lieu of the Tax ID:

Insurance Company(s): _____

Whose Name(s): _____ SSN#: _____

List each practice location i.e. Smith's Foot Clinic or Universal Foot Clinic – NOT Service Facilities i.e. Hospitals or Wound Care Facilities. **Provide a copy of ALL Practice Locations**

Name of **Primary Office**: _____

Address: _____City: _____

State: ___ Zip+4: _____ Phone: (____) _____

Fax: (____) _____ Back Office Line: (____) _____

Contact person: _____ Phone # (____) _____

(If different from the practice) Email Address: _____ NPI#: _____

Date first Medicare patient treated at this practice location: _____

If different from practice, please provide your "Pay To" Address: _____

_____ City: _____ State: ____ Zip+4: _____

Does your primary office accept **Credit Cards**? ____ Yes ____ No

____ Mastercard ____ Visa ____ American Express ____ Discover

Do ALL locations accept credit cards? ____ Yes ___ No Which locations do not accept credit cards?

(Please make a copy of this page for additional practice locations)

Name of **2nd Location**: _____

Address: _____City: _____

State: ___ Zip+4: _____

Phone: (____) _____ Fax: (____) _____ Back Office Line: (____) _____

Contact person: _____ Phone # (____) _____

Email Address: _____ NPI#: _____

Date first Medicare patient treated at this practice location: _____

City: _____ State: ____ Zip+4: _____

Contact person: _____ Phone # (____) _____

Email Address: _____

Name of 3rd **Location**: _____

Address: _____City: _____

State: ___ Zip+4: _____

Phone: (____) _____ Fax: (____) _____ Back Office Line: (____) _____

Contact person: _____ Phone # (____) _____

Email Address: _____ NPI#: _____

Date first Medicare patient treated at this practice location: _____

City: _____ State: ____ Zip+4: _____

Contact person: _____ Phone # (____) _____

Email Address: _____

Does your practice receive Electronic Fund Transfers (EFT) from any insurance? ___ Yes ___ No

****If you receive EFT's, we "need" a copy of the bank print out weekly.****

If yes, list Insurance Companies here: _____

_____

****Please provide a **Voided Check** or bank letter with account number and routing number.****

Who will be responsible for providing the above information? _____

Does your practice participate in any **Capitated Insurance Plans**? ___ Yes ___ No

If YES, list the insurance plan and their requirements for submission (i.e. Avmed sent to PMMI, the address, and must be submitted on paper by the 15th of the following month).

_____

Do you participate with any other insurance companies that have special requirements? ___ Yes ___ No

If yes, please list them: _____

PRACTICE GROUP INFORMATION

GROUP NPI # (if applicable)	
MEDICARE #	
RAILROAD MEDICARE #	
MEDICAID #	
BLUE CROSS BLUE SHIELD #	
TRICARE #	
List any other Group #'s	
For DME, list Supplier # for **each location**	

For a Professional Corporation (PC) or a Limited Liability Corporation (LLC), date of incorporation: _____

****Please send us copies of your practices State License, CP575 (from the IRS) and W-9****

If you are requesting PBS to help Credential you and your practice with insurance companies, on a separate sheet of paper, please list all adverse legal actions taken against this practice. Please include the date of incident, action taken and status. If this does not apply to your practice please circle: **NO ACTIONS**

FACILITY INFORMATION List every service facility excluding offices. Copy this page for additional facilities. (Type: Hospital=HOS Wound Care=WC Nursing Home=NH Surgery Center=SC Assisted Living Facility=ALF)

Type: ___________ Name: ____

NPI #: ________________________ Contact person: ____________________________________

Address: ____

City: ____ State: _____ Zip+4:_______________

Phone # (_____) ______________________ Fax # (_____) __________________________

Type: ___________ Name: ____

NPI #: ________________________ Contact person: ____________________________________

Address: ____

City: ____ State: _____ Zip+4:_______________

Phone # (_____) ______________________ Fax # (_____) __________________________

Type: ___________ Name: ____

NPI #: ________________________ Contact person: ____________________________________

Address: ____

City: ____ State: _____ Zip+4:_______________

Phone # (_____) ______________________ Fax # (_____) __________________________

Type: ___________ Name: ____

NPI #: ________________________ Contact person: ____________________________________

Address: ____

City: ____ State: _____ Zip+4:_______________

Phone # (_____) ______________________ Fax # (_____) __________________________

FACILITY INFORMATION (continued)

Type: _____ Name: _____

NPI #: _____ Contact person: _____

Address: _____

City: _____ State: ____ Zip+4:_____

Phone # (_____) _____ Fax # (_____) _____

Type: _____ Name: _____

NPI #: _____ Contact person: _____

Address: _____

City: _____ State: ____ Zip+4:_____

Phone # (_____) _____ Fax # (_____) _____

Type: _____ Name: _____

NPI #: _____ Contact person: _____

Address: _____

City: _____ State: ____ Zip+4:_____

Phone # (_____) _____ Fax # (_____) _____

To complete the setup process, please mail us the following information:

___ FEE SCHEDULE ____ MOST FREQUENTLY USED PRIMARY PHYSICIANS AND THEIR NPI #'S

___ MOST COMMONLY USED INSURANCE COMPANIES in your practice (Addresses and Phone #'s)

___ STATE MEDICAL LICENSE ___ CP575 (from the IRS) ___ W-9

We have most insurance companies on file. If you provide Capitated Services, send claims to local insurance companies or treat Worker's Comp patient's, please send a list of these plans.

___ LETTER OF MEDICAL NECESSITY FOR EACH PROVIDER AND PRODUCT USED. (A standard form is fine for all products.) ___ FAX COVER SHEET ___ OFFICE LETTERHEAD

___ CURRENT SUPERBILL OR ENCOUNTER FORM (We have Superbill examples you can select.)

___ OFFICE SCHEDULES (Office, Day at that location, Time Slots)

LIST OF USER NAMES AND PASSWORDS FOR OUR SYSTEM (Please list each employee that you want access into the system. List their full name, what the login will be, what they would like their password to be and what access you want them to have (i.e. Full access for office manager and/or Doctor, Appt Only - employee makes appointments only or Limited access – employee does a little of everything but can not view provider financial reports.

IF YOU ARE CURRENTLY USING A COLLECTION COMPANY AND WISH US TO USE THEM FOR YOUR ACCOUNTS, SEND COLLECTION COMPANY INFORMATION.

IF YOU WISH US TO CHECK ON YOUR NPI #'S AND CAQH INFORMATION, PLEASE PROVIDE USERNAMES AND PASSWORDS FOR ALL. (We will be happy to help you with this information, but once we update the information it will be up to you or your office to keep up with all future updates.)

Confidentiality Agreement

The information provided above shall be considered Confidential Information, used solely for the purpose(s) of conducting business on behalf of the named client. No Confidential Information shall be disclosed or transferred to any third party without the authorization of the client. By signing below I authorize Podiatry Billing Services to release any Confidential Information necessary to conduct business on my behalf.

Signature: _____ Date: _____