CBHA Provider Location Information Sheet

Provider name_______________________________________

Practice name____

Primary – Practice Physical Address
____
____
____

Secondary – Practice Address
____
____
____

Mailing address

____
____
____

Effective date (of new or change of address)
____

End date (of an old address if leaving)
____

Payment address
____
____
____

ADDITIONAL NOTES

____

____

Tax ID#____________________

Provider NPI#______________________

Practice Phone# ____________________________________

Practice Fax#____

Email Address_______________________________________

Please fax form to 888-908-7140 to Provider Relations Thank you.

Donna Cuff

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