

Podiatry Billing Services, Inc.
5018 Spring Park Road
Jacksonville, Fl 32207
CONFIDENTIAL CLIENT INFORMATION

Legal Name of Practice: _____

Federal Tax ID #: _____ SSN#: _____ NPI#: _____

If any insurance companies use your Social Security number in lieu of the Tax ID, please list the companies:

List each practice location i.e. Smith's Foot Clinic or Universal Foot Clinic – NOT service facilities i.e. Hospitals or Wound Care Facilities.

Name of Primary Office: _____

Address: _____

Phone: () _____ Fax: () _____ Back phone line: () _____

Contact person: _____ Phone # () _____

Email Address: _____

Date you saw your first Medicare patient at this practice location: _____

Is this your pay to address? Yes ___ No ___

If No, enter pay to address: _____

Contact person: _____ Phone # () _____

Email Address: _____

Name of 2nd Location: _____

Address: _____

Phone: () _____ Fax: () _____ Back line: () _____

Contact person: _____ Phone () _____

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Email Address: _____

Date you saw your first Medicare patient at this practice location: _____

Name of 3rd Location: _____

Address of 3rd Location: _____

Phone # _____ Fax# _____

Back line phone # _____ NPI # _____

Contact person and phone: _____

Date you saw your first Medicare patient at this practice location: _____

Name of 4th Location: _____

Address of 4th Location: _____

Phone # _____ Fax # _____

Back line phone # _____ NPI # _____

Contact person and phone: _____

Date you saw your first Medicare patient at this practice location: _____

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Name of 5th Location: _____

Address of 5th Location: _____

Phone # _____ Fax # _____

Back line phone # _____ NPI # _____

Contact person and phone: _____

Do you accept credit cards in your office? _____yes _____no

If yes, list them here: _____

Do you get Electronic Fund Transfers from any insurance? _____yes _____no

If yes, list Insurance Companies here: _____

****For our records, send a voided check or a letter from the bank with account information on it (ie account # and bank routing #).**

If you receive EFT's, you must inform us of them at least once a week with a bank print out.

Who in your office will be accessing this information and sending it to us? _____

Is your office Capitated with any Insurance Company? _____yes _____no

If yes, list the insurance plan and their requirements for submission (ie Avmed goes to PMMI @ this address and must be submitted on paper by the 15th of the following month).

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Do you have any other insurance companies that have special requirements? _____ yes _____no

If yes, list them here: _____

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PRACTICE GROUP INFORMATION

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

For a professional corporation or a limited liability company enter Incorporation Date here: _____

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

For Credentialing purposes, 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

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FACILITY INFORMATION

(List every service facility excluding offices)
(please 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: _____

Phone # _____ Fax # _____

Type: _____ Name: _____

NPI #: _____ Contact person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ Fax # _____

Type: _____ Name: _____

NPI #: _____ Contact person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ Fax # _____

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PROVIDER INFORMATION

(Please copy this page for each provider that we are billing for)

Name: Gender: Male Female	
Social Security #	
Date of Birth	
City and County of Birth	
Birth State and Country	
Medical License # Issue and Expiration Dates	
Individual NPI #	
Medical School Name Start & Graduation Dates	
DEA # and Expiration date	
Email address	
Medicare #	
Railroad Medicare #	
Medicaid #	
Blue Cross Blue Shield #	
Tricare #	
List any other #'s	

Toll Free: 800-394-1169

Tel: 904-348-6606

Fax 904-348-6612

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On a separate sheet of paper, list any adverse legal actions taken against this provider. Please include the date of incident, action taken and status.

If this does not apply to you, please circle: NO ACTIONS

****Please send us copies of your CV, Medical license, Liability insurance information and Drivers License.**

MAIL US THE FOLLOWING INFORMATION:

ALL INFORMATION REQUESTED ON EACH SHEET MARKED WITH (** and in **BOLD**)

FEE SCHEDULE

MOST FREQUENTLY USED PRIMARY PHYSICIANS AND THEIR NPI #'S

MOST COMMONLY USED INSURANCE COMPANIES in your practice (Addresses and Phone #'s)
We do have most insurance companies on file, but if you have capitated plans, uncommon insurance companies, or see 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 LETTER HEAD

YOUR CURRENT SUPERBILL OR ENCOUNTER FORM
(We have some standard forms that we can match up with yours.)

OFFICE SCHEDULES (which office & when ie Westside every Monday 9am to 5pm Lunch 12:00 to 1:30)

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 (ie 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.)

Toll Free: 800-394-1169

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Fax 904-348-6612

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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: _____