

PRACTICE QUESTIONNAIRE

1. Name of Practice: _____
2. Address of Practice: _____
3. Service Specialty: _____
4. Is the organization incorporated: YES NO If yes, in which state is it incorporated?

5. What is the Employer Identification Number of the organization? (Give all numbers and hyphens): _____
6. Please attach a list of the names and titles of the principal officers of the organization.
7. Please attach a list of all health care practitioners and their professional status.
8. Please attach a list of the services or types of service you provide your patients or patrons. (Superbill)
9. Is any part of your practice hospital affiliated or based? YES NO If yes, please indicate the hospital and for what types of services.

10. Is the reimbursement to the professional members of the organization based on the following? **(Please designate)** Salary Percentage of Income Fee for Service
11. Are the services of the organization offered on the basis of: **(Please designate)**
 Fee for Service Pre-Paid Other (Describe) _____
12. Is the organization funded by city, state or federal monies? If yes, please indicate the source of the funding and the purpose for which it is to be used (ex., Patient Care, Administration, Teaching, etc.).

13. Is the organization funded by any other outside group, corporation, or agency? If yes, please identify group, corporation or agency.

14. Mailing Address (To receive claim forms, publications and other correspondence)

Street Address	Office Telephone Number		
City	State	County	Zip Code

15. Payment Address (To receive reimbursement checks)

Street Address	Office Telephone Number		
City	State	County	Zip Code

Name (Please Print)

Signature

Title

Telephone Number

Date

Mail this form to:
CareFirst BlueCross Blue Shield
Attn: Provider Information and Credentialing, Mail Stop CG-41
10455 Mill Run Circle
P.O. Box 825
Owings Mills, MD 21117-0825