

Demographic Verification and Authorization Completed and authorized on behalf of the practitioner by:											
Organizati								-			
Organization Name:											
		nic Information for thi									
*****As	shown on your s	state License*****									
Last:		First:				MI:	S	SN:			
Title:		MBBS Other					DOB:				
	DC DPM	DDS Title:					E Female	🔲 М	ale		
DEA:		State: T	ype I NPI:			Licens	e Number:		State:		
Languag	es spoken fluently t	o treat patients:									
ADD/RE	EMOVE Practitio	ner									
Practicir	ng as: 🗌 Primar	y Care 🛛 Specialis	t 🗌 Urgent	Care	] Locun	n Tenens	☐ Moonlighting	Reside	ent 🗌 Hospitalist		
	Hospital Base	d only 🛛 Teaching	/Research only	y 🗆	] Other	(specify) _					
Clinic	Hospital Clin	ic/Hospital Name:		1							
Address:				City/State				Zip:			
Tax ID:	Туре	e 2 Site NPI:	Directory □ YES	Suppress?		/ Sees Patients YES □	s Here at Least Once Pe *NO □	r Week?	Accepting New Patients?		
Effective	Date:	Practicing Specialty at	this Site:				Primary Site?	□ YE	S 🗌 NO		
		Remove ALL sites f	or this TIN? Y	ES NO		Remove F	Reason:				
ADD/RE	EMOVE Practitio	ner									
	ig as: 🗌 Primary		t 🗌 Urgent	Care	] Locum	n Tenens	Moonlighting	Reside	ent 🗌 Hospitalist		
	Hospital Base	d only 🛛 Teaching	/Research only	y 🗆	] Other	(specify) _					
Clinic	Hospital Clin	ic/Hospital Name:									
Address:				City/State	):			Zip:			
Tax ID:	Туре	2 Site NPI:	□ Yes [	Suppress? □No		v Sees Patients YES □	Here at Least Once Per*	Week?	Accepting New Patients? YES I NO I		
Effective	ective Date: Practicing Specialty at this Site:						Primary Site?  YES  NO				
		Remove ALL sites f	or this TIN? Y	ES 🔲 NO		Remove F	leason:				
CHANG	E Practitioner D	emographic Data									
Effective Date of Change:											
Old: Last Nam	ne:			<u>New:</u> Last Nar	ne:						
First Nan		MI:		-	-			MI:			
Specialty				Specialty	/:						
License #	¥:	State:		License	#: _				State:		
DEA #:				DEA #:							
List add	ditional practic	e locations to ADD	/REMOVE o	n the Site	e Loca	ation Add	endum and att	ach to	o this form.		
Ch	eck here if you hav	ve additional Site Locati	ion Addendum	forms atta	ched.						

## THE FOLLOWING SITE LOCATION ADDENDUM FORM IS USED IN CONJUNCTION WITH THE UNIFORM PRACTITIONER CHANGE FORM WHEN ADDING OR REMOVING PRACTITIONERS FROM MORE THAN TWO SITES. THIS FORM WILL ONLY BE ACCEPTED WHEN IT IS ACCOMPANIED BY A COMPLETED UNIFORM PRACTITIONER CHANGE FORM.

## SITE LOCATION ADDENDUM

1	(Please	make as	many	extra	copies	as	necessary	')
	<b>`</b>							

## ADDITIONAL LOCATION(s) FOR:

Last:				First:				MI:	NPI:		
ADD/REMOVE Practitioner											
Practicing a	s: 🗌 Pr	imary	Care	Specialist 🗌	Urgen	t Care	🗌 Locui	n Tenens	Moonlighting	Reside	ent 🗌 Hospitalist
	Hospital E	Based	only	Teaching/Re	search onl	ly	Other	(specify) _			
Clinic	] Hospital	Clinio	c/Hospital	Name:							
Address:						City/s	State:			Zip:	
Tax ID:		Туре	2 Site NP	1:	Directory		ss? Regular	y Sees Patients	s Here at Least Once Per *NO □	Week?	Accepting New Patients? YES D NO D
Effective Da	te:		Practicir	ng Specialty at this	Site:				Primary Site?		S 🗌 NO
		OVE	Rem	ove ALL sites for th	nis TIN? Y	'ES 🗌	NO	Remove F	Reason:		
ADD/Remo	ove Pract	itione	er					1			
Practicing a	s: 🗌 Pr	imary	Care	☐ Specialist	Urgent	t Care	🗌 Locur	n Tenens	🗌 Moonlighting I	Reside	ent 🗌 Hospitalist
	Hospital E	Based	only	☐ Teaching/Re	search onl	ly	Other	(specify) _			
Clinic	] Hospital	Clinic	c/Hospital	Name:							
Address:						City/s	State:			Zip:	
Tax ID:		Туре	2 Site NP	1:	Directory		ss? Regularly	/ Sees Patients	Here at Least Once Per V *NO □	Veek?	Accepting New Patients? YES D NO D
Effective Da	te:		Practicir	ng Specialty at this	Site:		I		Primary Site?	T YES	S 🗌 NO
		OVE	Rem	ove ALL sites for th	nis TIN? Y	'ES 🔲	NO	Remove F	Reason:		
ADD/REMO	OVE Pract	ition	er								
Practicing a	s: 🗌 Pr	imary	Care	Specialist	Urgen	t Care	🗌 Locur	n Tenens	Moonlighting I	Reside	ent 🗌 Hospitalist
	Hospital E	Based	only	☐ Teaching/Re	search onl	ly	Other	(specify) _			
Clinic	] Hospital	Clinic	c/Hospital	Name:							
Address:						City/s	State:			Zip:	
Tax ID:		Туре	2 Site NP	1:	Directory		ss? Regular	ly Sees Patients	s Here at Least Once Per	Week?	Accepting New Patients?
					□ YĘS	□ NO		YES 🗌	*NO 🗌		YES 🗌 NO 🗌
Effective Da	te:		Practicir	ng Specialty at this	Site:				Primary Site?		S 🗆 NO
		OVE	Rem	ove ALL sites for th	nis TIN? Y	'ES 🗖		Remove F	Reason:		
ADD/REM											
Practicing a		imary		☐ Specialist	Urgen	t Care	🗌 Locur	n Tenens	Moonlighting	Reside	ent 🗌 Hospitalist
	Hospital E	Based	only	☐ Teaching/Re	search onl	ly	Other	(specify) _			
Clinic	] Hospital	Clinio	c/Hospital	Name:							
Address:	-					Citv/s	State:			Zip:	
Tax ID:		Туре	2 Site NP	1:	Directory	Suppre		y Sees Patients	Here at Least Once Per	· ·	Accepting New Patients?
Effective Da	te <sup>.</sup>	<u> </u>	Practicir	ng Specialty at this	Site:	□ NO		YES 🗌	*NO 🗌		YES 🗌 NO 🗌
			1 100001	S openany at 1115	ono.				Primary Site?	□ YES	S 🗌 NO
ADD		OVE	Rem	ove ALL sites for th	nis TIN? Y	'ES 🗌	NO	Remove F	Reason:		