CATHOLIC MEDICAL PARTNERS - OFFICE OPERATIONS/ DATA REQUEST

Nurse Practitioner/Physician Assistant Name:
NP or PA (please circle) **Date of Birth:** **Gender:**

Specialty: **Languages Spoken:**

Office/Practice Name:

Office/Practice Address:

City:	**State:**	**Zip:**
Phone:	**Fax:**	

Email Address:

Office Manager/Primary Office Contact:

Office Manager/Primary Office Direct Extension:

Office Manager/Primary Office Contact Email:

NPI Number:	**CAQH ID Number:**
UPIN Number:	**DEA Number:**

Practice Tax ID Number:

Nurse Practitioner/Physician Assistant New York State Medical License Number:	**License Exp. Date:**

BOARD ELIGIBILITY: CIRCLE: IF N/A **N/A**

Certified/Eligible by Board of:
(circle one) **N/A**

Certificate Number: **N/A**	**Year Certified:** **N/A**

Primary Hospital (Please Check): ☐**Kenmore** ☐**Mercy** ☐**Sisters** ☐**Mt St. Mary's** ☐**Bertrand Chaffee**
Other:

Accepting New Patients (Please Check): ☐**YES** ☐**NO**

Electronic Health Record Vendor Name :_____

Please Fill Information Below for Prescribing Nurse Practitioner/Physician Assistant:
PLEASE PRINT CLEARLY

NAME	Degree	NPI #	IH Provider #	HN Provider # (BC/BS)	Univera Provider #
		Listed above for applicant			
	NP/PA Midwife				
	NP/PA Midwife				
	NP/PA Midwife				
	NP/PA Midwife				