Contact Form

Practice name: Group NPI:

Practice open to new patients? (Check one) Yes ☐ No ☐

Part of a larger organization? (Check one) Yes ☐ No ☐

Name of organization:

Tax ID of organization:

Physical Address (location patients are seen)

Street: Suite:

City/State/Zip:

Phone #: Fax:

Mailing Address (location for correspondence)

Street: Suite:

City/State/Zip:

Phone #: Fax:

Billing Address (location on claims)

Street: Suite:

City/State/Zip:

Phone #: Fax:

Practice/Office Manager (person responsible for all operations of practice)

Name: Title:

Email: Fax:

Phone #:

Credentialing Contact (person in their office for us to ask questions to)

Name: Title:

Email: Fax:

Phone #:

<u>Person completing Contact Form</u>

Name: Title:

Email: Fax:

Phone #:

Mail to:

Please send completed document to:

Beacon Health
Attn: Provider Management
797 Wilson Street, Suite 2
Brewer, ME 04412

beaconprovmgmt@northernlight.org

or fax to **(207) 973-7160**