

PROVIDER INFORMATION

Name, First: _____ MI: _____ Last: _____

Title: _____ Specialty(s): _____ Male Female

Facility Name: _____ FEIN #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

Email Address: _____ Contact Person: _____

Nurse Practitioners:

Physician(s) with whom you have a working collaborative agreement: _____

Audiologists:

Do you perform ABR testing on newborns? Yes No

Do you perform OAE testing for newborns? Yes No

LICENSURE/CERTIFICATION

Profession	License #/ Certificate	State	Expiration Date

ADDITIONAL PRACTICE LOCATIONS

- ◆ If applicable, list your additional sites of service. You must include a copy of W-9 and/or insurance certificate if the FEIN or insurance coverage is different than your primary location.

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____

Insurance Coverage: Same as Primary Site If not, list carrier: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ County: _____

FEIN: Same as Primary Site If not, list FEIN: _____

Insurance Coverage: Same as Primary Site If not, list carrier: _____

LIABILITY INSURANCE INFORMATION

The University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC) requires that all providers providing services to UIC-DSCC clients maintain professional and general liability insurance, as required by law in Illinois or state of practice.

Provider maintains this coverage and will provide copies of an insurance certificate upon request.

Failure of UIC-DSCC to obtain proof of coverage shall not be deemed to be a waiver of the coverage requirement.

Please check the appropriate box:

- Professional Commercial Provider – Home Modification Commercial All Other
(Requires copy of insurance certificate)

I/designee attest that the information provided is accurate to the best of my knowledge and give UIC-DSCC permission to verify such as needed.

I/designee have reviewed the UIC-DSCC Medical Benefit and Billing guidelines for providers

Provider is not excluded from participation in Medicare, Medicaid or any other federal or State healthcare program.

Provider's/Designee's Signature: _____ Date: _____