

**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: \_\_\_\_\_