

**PROVIDER PROFILE VERIFICATION BELOW**

**PLEASE PROVIDE US WITH YOUR CURRENT INFORMATION SO THAT WE CAN BETTER SERVE YOU.**

<b>Last Name:</b>				<b>First Name:</b>				<b>M.I.</b>															
<b>Specialty:</b>				<b>PCP Panel (IM, FP, PEDs)</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>Accepting New Patients:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>EPSDT Certified:</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>Health Choice-Medicaid (MPC)</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>Maryland Health Insurance Plan (MHIP)</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>Primary Adult Care (PAC)</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>Medicare Advantage</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>Listed in the Directory</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>Languages (Please list):</b>				<b>Age Requirements:</b>				<b>Office Hours:</b>											
<b>Pay to name on W9 form:</b>								<b>EDI (HCFA/UB)</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>More information on Electronic Claims?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>Tax ID Number:</b>						<b>NPI #</b>						<b>License #</b>											
<b>Primary Practice Address: (please include STE#)</b>												<b>Primary Practice</b>  <b>Phone:</b> <b>Fax:</b>  <b>Email:</b>											
<b>Pay To/Billing Address:</b>												<b>Pay To/Billing Address:</b>  <b>Phone:</b> <b>Fax:</b>  <b>Email:</b>											
<b>Additional Practice Address: (If more than one, please submit on separate sheet)</b>												<b>Additional Practice</b>  <b>Phone:</b> <b>Fax:</b>  <b>Email:</b>											

**PLEASE MAIL OR FAX INFORMATION TO:**

Maryland Physicians Care  
Provider Relations  
509 Progress Dr., Suite 117  
Linthicum, MD 21090-2256  
Phone: (800) 953-8854 Option 2, Option 3  
Fax: (410) 609-1927

[www.MarylandPhysiciansCare.com](http://www.MarylandPhysiciansCare.com) / [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us)

**PLEASE INCLUDE W9 FORM AND IF APPLICABLE, PHYSICIAN ROSTER/PRACTICE LOCATIONS**

THANK YOU FOR YOUR ASSISTANCE