



PROVIDER PROFILE VERIFICATION BELOW

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

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

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

THANK YOU FOR YOUR ASSISTANCE