billingline

PROVIDER INFORMATION

Practice Name: _____

Name of Provider: _____

License #: _____

Your Degree(s): _____

Service Address: Mailing Address (if different):

_____ _____

_____ _____

Office Phone #: _____ Office Fax #: _____

Office E-mail: _____

(If you have more than one service location, please include all service addresses, phone and fax #'s. Please indicate which days you are at which office.)

Your Date of Birth: _____

Tax ID # / Social Security #: _____ ☐ Tax ID ☐ SS

NPI #: _____

Taxonomy #: _____

billingline
82 COUNTY ROAD PMB #3 - MATTAPOISETT, MA 02739
PHONE: 508 207 5624 - FAX: 508 748 1561 - BILLINGLINE@VERIZON.NET