

# Practice Application

## I. PRACTICE INFORMATION

*Practice Information: Please complete a separate application for each practice.*

Practice Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Scheduling Phone: \_\_\_\_\_ Scheduling Fax: \_\_\_\_\_

Federal Tax I.D. No: \_\_\_\_\_ Practice NPI No: \_\_\_\_\_

Website Address: **www.** \_\_\_\_\_

Office Manager Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ Email: \_\_\_\_\_

Scheduling Mgr. Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ Email: \_\_\_\_\_

Claims Manager Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ Email: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ Email: \_\_\_\_\_

**Mailing Address (if different than above)**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Billing Address (if different than above)**

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Business Phone: \_\_\_\_\_ Billing Business Fax: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ ext. \_\_\_\_\_ Email: \_\_\_\_\_

**Ownership:** *Please check Type of Ownership:*

Sole Proprietorship   Partnership   Corporation   Hospital Corporation   Limited Liability Co. (L.L.C.)   Other

Please list the owners of this Diagnostic Practice and the percent of ownership: **(Ownership must equal 100%):**

Last Name, First Name, Middle Initial	Phone Number	Email Address	Medical License #	SS Number	% of Ownership

## II. SERVICES

**Services:** Please check all that apply...

Do you provide transportation for patients to your facility?    Yes    No

**Neuro:**    EMG    NCV

Do you provide Sedation?    Yes    No    Notes: \_\_\_\_\_

III. PRACTICE HOURS	SCHEDULING DEPARTMENT HOURS
---------------------	-----------------------------

Monday: _____ From: _____ To: _____	Monday: _____ From: _____ To: _____
Tuesday: _____ From: _____ To: _____	Tuesday: _____ From: _____ To: _____
Wednesday: _____ From: _____ To: _____	Wednesday: _____ From: _____ To: _____
Thursday: _____ From: _____ To: _____	Thursday: _____ From: _____ To: _____
Friday: _____ From: _____ To: _____	Friday: _____ From: _____ To: _____
Saturday: _____ From: _____ To: _____	Saturday: _____ From: _____ To: _____
Sunday: _____ From: _____ To: _____	Sunday: _____ From: _____ To: _____

## IV. DOCUMENTATION CHECKLIST

**Please remember to include copies of the following documents with your completed application.**

- Copy of W-9 Form
- Roster of Physicians and Physician Application (s)

*Please return this form to:*

**Carisk Specialty Services, LLC  
180 Park Ave. Plaza Level, Suite LL103  
Florham Park, NJ 07932**

**Email: [providerrelations@cariskpartners.com](mailto:providerrelations@cariskpartners.com)  
Fax: 844-898-6135**

