SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

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TTY: 711
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Practice Information Request

Please attach a copy of your W-9.

Primary office information		
Practice name (to whom the check is payable). **This practice name must exactly match the name listed with the IRS and on your federal tax identification number.**		
Clinic or office name (if different)		
Address		
Clinic manager email address	Alternate email address with title	
Telephone: Office (day)	Appointment phone number	Fax number
Clinic website	Facility compliant with the Americans with Disabilities Act (ADA): ☐ Yes ☐ No	
Federal tax ID #	Type 2 NPI	
Clinic/Office manager	Telephone	
Is this the primary Security Health Plan contact person: ☐ Yes ☐ No If no, provide name		

Billing address	
(If different than primary clinic site)	
Name	
Address	
Contact person	Telephone
Should this address be used for communications other than billing: ☐ Yes ☐ No	

Additional office information

(If you have more than one additional site, please attach list following this guideline)

Clinic or office name

Address

Telephone: Office (day)	Appointments	Emergency/After hours
TDD number (if any)	Fax number	

Billing address, if different than primary clinic site

Federal tax ID #	Type 2 NPI
Clinic/Office manager	Telephone

Facility compliant with the Americans with Disabilities Act (ADA): ☐ Yes ☐ No

Patient access information

What arrangement do your providers have for 24-hours-a-day/7-days-a-week coverage for your patients:

After-hours answering service: ☐ Yes ☐ No 24-hour call coverage: ☐ Yes ☐ No

Usual care for after-hours patient needs:

☐ Referred to ER ☐ Seen by on-call doctor in office

☐ Referred to urgent care ☐ Seen by on-call doctor in ER

Please attach any other pertinent information related to patient access

Other clinic information

Are you a rural health clinic: ☐ Yes ☐ No

If yes, provide your clinic Medicare number _____

Is your clinic Medicaid certified: ☐ Yes ☐ No If yes, State of WI billing number _____

Is your clinic Medicare certified: ☐ Yes ☐ No If yes, Medicare billing number _____

Does your practice utilize a fully functional electronic medical record: ☐ Yes ☐ No

Does your practice use a clearinghouse: ☐ Yes ☐ No

If yes, provide name of clearinghouse _____

Provide us with the following practice/facility numbers:

DMERC _____ CLIA _____ Mammo _____

Date form completed (month/day/year) _____ /_____ /_____

For office use only	Effective date	Group practice
Networks		
Practice type	Print directory: ☐ Yes ☐ No	Office status ☐ ☐
Group practice name	Contract practice number	
Contract IDs		
Provider rep		