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

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

SCHEDULING DEPARTMENT HOURS

Monday: _____ From: _____ To: _____
Tuesday: _____ From: _____ To: _____
Wednesday: _____ From: _____ To: _____
Thursday: _____ From: _____ To: _____
Friday: _____ From: _____ To: _____
Saturday: _____ 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
Fax: 844-898-6135