Practice Name (legal business name):

_____

DBA (if applicable):_____

TIN: _____

Practice Address: _____

Remittance Address (if different from practice address): _____

_____

Checks should be made out to: _____

TIN: _____

Telephone: _____ Fax: _____

Billing contact (Name): _____ Title: _____

Email address for billing contact person: _____

Contract contact (Name): _____ Title: _____

Email address for contract contact person: _____

Unique Entity ID: _____

Specialties (if applicable): _____

Languages spoken: _____

Please provide an estimate on the number of unduplicated Lifelong patients you believe you will be able see each month: _____

Office Hours

	START	AM or PM	END	AM or PM		START	AM or PM	END	AM or PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

Location (place an X in the box next to your locations)

KING		SNOHOMISH		ISLAND	
	Seattle		**Lynnwood**		**Oak Harbor**
	Eastside (Bellevue, etc.)		**Everett**		**Coupeville**
	Eastern (Carnation, etc.)		**Snohomish**		**Camano**
	South (Auburn, etc.)		**North** (Arlington, etc.)		**Clinton**
	Tukwila		**Eastern**		**Other:**
	North (Shoreline, etc.)		**Other:**		
	Other:				

Medicaid

Does your practice accept Medicaid? ☐ Yes ☐ No

	Yes	No	
1			Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?
2			Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice?
3			Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?
4			Are you currently under any investigation with respect to your DEA or state controlled substances registration?
5			Have any disciplinary proceedings ever been instituted against you, or are any disciplinary actions now pending with respect to your license?
6			Have you ever been denied, reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participation in Medicare, Medicaid or any other governmental or quasi-governmental health-related program?
7			Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed or terminated by action of an insurance company?
8			Have any professional liability suits ever been entered against you, or are there any claims pending?
9			Have any professional liability claims settlements, not involving litigation or arbitration, ever been paid by you or paid on your behalf?
10			Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you to assure that you are not engaging in the illegal use of controlled dangerous substances?

11			Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
12			Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?