



**PEIA Face to Face Care Management Program  
Provider demographic data form  
[One form must be completed for each practice site.]**

**Effective Date:** \_\_\_\_\_

**Provider name:** \_\_\_\_\_

**Face to Face Provider:** \_\_\_\_\_

**TIN (Tax Identification Number):** \_\_\_\_\_  
(Number that appears in Block 25 of CMS 1500 Form)

**Facility Site Address:** \_\_\_\_\_

**Mailing Address**  
(if different from practice street address): \_\_\_\_\_

**County:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_  
(Number used to make appointments)

**Claims Payment Address:** \_\_\_\_\_  
(The address that appears in Block 33 of CMS 1500 Form.)

**Contact Person's Name and Title:** \_\_\_\_\_

**Name of person completing this form:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Provider NABP number** \_\_\_\_\_

**Does your facility have a CLIA  
(Clinical Laboratory Improvement Act) waiver ?**                      **YES**                      **NO**

**Please return this completed form and a copy of the Provider's license and W-9 form.**