PROVIDER ROSTER

Clinic Name: _____

Address: _____

City: _____ **State:** _____ **Zip:**_____

Telephone #: _____ **Fax:**_____

Tax ID: _____ **E-Mail:**_____

Contact Name: _____

Provider Name (please print) **License** (i.e. MD, LCSW) **NPI**

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Add another sheet if necessary.