Office Information Sheet

Office Contact Information

Practice/Company Name: _____

Address: _____

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

Phone: _____ **Fax**: _____

Group Tax ID: _____

Practice/Company Email Address: _____

Doctor Taxpayer Identification Numbers associated with this office (attach separate list if needed):

- _____
- _____
- _____

Primary Contact Information (SuperUser)

Contact Name: _____

E-mail: _____

Phone: _____

Secondary Contact Information (Backup SuperUser)

Contact Name: _____

E-mail: _____

Phone: _____

***Authorized Signature:** _____ Date: ____/____/_____

(Owner, Provider or Legal Representative)

***Authorized Signer Print Name:** _____

***Job Title:** _____

Phone #: (_____) _____

Applications without the appropriate Authorized Signature as defined in the HealthConnect New Office Packet Instructions will not be processed.

If you have any questions regarding this form call the Renown Health Help Desk at 775-982-4042.