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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [http://www.skillexpertiseandtechnology.com/emailtemplate_images/Email_sign_HTH.png](http://www.hometownhealth.com/) | | | **Hometown Health ROSTER TEMPLATE** | | | | | | | | |
| INSTRUCTIONS: Please attach additional copies of this page if you need to list more than 10 locations. | | | | | | | | |
|  | | | | | | | | | | | |
| **Practice Legal Name:** | |  | | | | | | **Practice Tax ID:** | |  | |
| **Practice Medicaid #:** | |  | | | | | | | | | |
|  | **Billing Address Name** | **Address (including Suite #)** | | **City** | **State** | **Zip** | **Phone** | | **Fax** | |  |
|  |  |  | |  |  |  |  | |  | |  |
|  | **Facility / Office Location Name** | **Address (including Suite #)** | | **City** | **State** | **Zip** | **Phone** | | **Fax** | | **Days and Hours of Operation** |
| 1 |  |  | |  |  |  |  | |  | |  |
| 2 |  |  | |  |  |  |  | |  | |  |
| 3 |  |  | |  |  |  |  | |  | |  |
| 4 |  |  | |  |  |  |  | |  | |  |
| 5 |  |  | |  |  |  |  | |  | |  |
| 6 |  |  | |  |  |  |  | |  | |  |
| 7 |  |  | |  |  |  |  | |  | |  |
| 8 |  |  | |  |  |  |  | |  | |  |

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| [http://www.skillexpertiseandtechnology.com/emailtemplate_images/Email_sign_HTH.png](http://www.hometownhealth.com/) | | **ROSTER TEMPLATE OF INDIVIDUAL PRACTITIONERS** | | | | |
| INSTRUCTIONS: Please attach additional copies of this page if you need to list more than 10 individual practitioners. Under Provider Specialties, you may add additional numbering if the physician or non-physician medical professional has more than 2 (two) specialties that they either support or practice. For NP & PA professionals, please be sure to indicate their degree and the primary & secondary specialties which they support. Under Locations and Days and Hours of Operation at Each Location, you may add additional numbering if the individual practitioner practices at more than 3 (three) locations. | | | | |
|  | |  | | | | |
| **Practice Legal Name:** | |  | | | | |
| **#** | **Individual Practitioner Name** | **Degree (MD, DO, PA, NP…)** | **Specialties**  **1) Primary 2) Secondary** | **CAQH # (if applicable)** | **Type I (Individual) NPI #** | **List Each Practitioner’s Locations and Days / Hours at Each Location** |
| 1 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 2 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 3 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 4 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 5 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 6 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 7 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 8 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 9 |  |  | 1)  2) |  |  | 1)  2)  3) |
| 10 |  |  | 1)  2) |  |  | 1)  2)  3) |

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