STATE OF WASHINGTON

DEPARTMENT OF HEALTH

EARLY INTEVENTION PROGRAM PROVIDER AGREEMENT
APPENDIX A

All fields are required. If not applicable, please put "N/A"

CLINIC/PRACTICE INFORMATION					
Provider Name:		Federal Tax ID#:			
Facility Name:					
Facility Address:					
City:		State:		Zip:	

BUSINESS INFORMATION					
Appointment phone number:		Fax Number:			
Mailing address:					
City:		State:		Zip:	
Billing Address:					
City:		State:		Zip:	

CONTACT INFORMATION			
Office Manager/Admin:		Phone Number:	
Email Address:			
Credentialing Manager:		Phone Number:	
Email Address:			
Please provide an email address for EIP updates: *(you may include multiple)*			
Website Address:			

ADDITIONAL INFORMATION

May we post your practice on our website? ☐YES ☐NO

Do you have multiple office locations? ☐YES ☐NO
(if yes, please fill out Appendix B for all locations)

Would you like to receive your remittance advices for payments electronically? ☐YES ☐NO
(if yes, please fill out the Secure FTP form)