# Practice List

# Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical Group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Number of Practice Sites:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alliant Quality Initiatives Practice is participating in : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following information for all practices who intend to participate in Alliant Quality initiatives. Use an additional sheet if necessary The first row is an example.

|  |
| --- |
| **Practice List**  |
| **Organization NPI**  | **Practice Name****(If practice name is the same yet there are multiple practice sites, add the site name-see example below)** | **Practice Address, City, Zip** | **Practice Manager** | **Practice Manager Phone** | **Practice Fax**  | **Practice Manager Email**  |
| *121245456* | *ABC Medical Practice - Duluth* | *123 Hill State, Duluth, 30312* | *Cindy Hope* | *146-121-9837* | *146-121-9838* | *chope@abcmedical.com* |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

# Practitioner List

# Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Number of Practitioners:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alliant Quality Initiatives Practice is participating in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the following information for all practitioners within the practice. The first row is an example. Use an additional sheet if necessary.

1. Use the following codes to indicate specialty: (F) Family Practice; (G) Geriatrics; (I) Internal Medicine; Other (please specify).

2. Provide the National Provider Identifier for the individual provider, which consists of ten numeric digits.

|  |  |
| --- | --- |
|  | Practitioner Profile |
| **ABFM MOC Participant** | **First Name** | **Last Name** | **License Type (MD, DO, NP, PA)** | **Specialty1** | **Individual NPI2** | **Clinic Location (s) (if providers works at multiple locations)** |
|[ ]  Sara K. | Jones | MD | F | 1234567891 | Barber Clinic |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |
|[ ]   |  |  |  |  |  |

1. Use the following codes to indicate specialty: (F) Family Practice; (G) Geriatrics; (I) Internal Medicine; Other (please specify).

2. Provide the National Provider Identifier for the individual provider, which consists of ten numeric digits.