



DEMOGRAPHIC INFORMATION FORM

Provider Name:	Social Security Number:	Date of Birth (required):
Highest Degree:	National Provider Identifier	Tax Identification Number:

	Y = Yes	N=No	If Yes to A or B, you must enter numbers below.			
A. Accept Medicare Assignments?			Medicare UPIN:		State:	
			Insurance Carrier's PIN (if applicable):		State:	
			Insurance Carrier's PIN (if applicable):		State:	
B. Medicaid Provider?			Medicaid #:		State:	

SITE INFORMATION

Please supply us with your current mailing address information.

MAILING ADDRESS						
Location Name:						
Attention:						
Address:						
City:				ST:	ZIP:	
Phone #:				Ext.:	Fax #:	
Answering Service #:						
Emergency Phone #:						

HOME ADDRESS						
Address:						
City:				ST:	ZIP:	
Phone #:				Ext.:	Fax #:	
E-mail Address:						

MHS Control No.: RecipientGSPProviderID

Prov. Primary State: RecipientPrimarySiteState



DEMOGRAPHIC INFORMATION FORM

Please provide your current financial address information.
 Include Form W-9 for any Taxpayer Identification Number changes.

FINANCIAL ADDRESS		
Location Name:		
Address:		
City:	ST:	ZIP:
Phone #:	Ext.:	Fax #:

PRIMARY SERVICE ADDRESS							
Location Name:							
Address:							
City:	ST:	ZIP:					
Phone #:	Ext.:	Fax #:					
Answering Service #:							
E-mail:							
Taxpayer ID # (used with this address):							
OWNER for this Taxpayer ID #:							
Business Hours: (Mark applicable boxes with an "X")	M	T	W	TH	F	SA	S
Morning							
Afternoon							
Evening							
By Appt.							
¹ TDD capability? (circle) Y N	² Wheelchair accessible? (circle) Y N			³ I block to public transportation? (circle) Y N			

1. Does this location have telecommunications for the deaf capability? 2. Is this location wheelchair accessible? 3. Is this location located within one block of public transportation stop?

IF YOU ARE CONTRACTED WITH A GROUP(s)

Group Name	Group Practice National Provider ID # (NPI)	Group Primary Site Address

MHS Control No.: RecipientGSPProviderID

Prov. Primary State: RecipientPrimarySiteState



DEMOGRAPHIC INFORMATION FORM

Include an updated Form W-9 for any Taxpayer Identification Number changes.

ADDITIONAL SERVICE ADDRESS							
Location Name:							
Address:							
City:	ST:	ZIP:					
Phone #:	Ext.:	Fax #:					
Answering Service #:							
E-mail:							
Taxpayer ID # (used with this address):							
OWNER for this Taxpayer ID #:							
Business Hours: (Mark applicable boxes with an "X")	M	T	W	TH	F	SA	S
Morning							
Afternoon							
Evening							
By Appt.							
¹ TDD capability? (circle) Y N		² Wheelchair accessible? (circle) Y N			³ I block to public transportation? (circle) Y N		

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ADDITIONAL SERVICE ADDRESS							
Location Name:							
Address:							
City:	ST:	ZIP:					
Phone #:	Ext.:	Fax #:					
Answering Service #:							
E-mail:							
Taxpayer ID # (used with this address):							
OWNER for this Taxpayer ID #:							
Business Hours: (Mark applicable boxes with an "X")	M	T	W	TH	F	SA	S
Morning							
Afternoon							
Evening							
By Appt.							
¹ TDD capability? (circle) Y N		² Wheelchair accessible (circle) Y N			³ I block to public transportation? (circle) Y N		

MHS Control No.: RecipientGSPProviderID

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PM							
Evening							
By Appt.							
¹ TDD capability? (circle) Y N	² Wheelchair accessible? (circle) Y N			³ 1 block to public transportation? (circle) Y N			

ADDITIONAL SERVICE ADDRESS							
Location Name:							
Address:							
City:	ST:	ZIP:					
Phone #:	Ext.:	Fax #:					
Answering Service #:							
E-mail:							
Taxpayer ID # (used with this address):							
OWNER for this Taxpayer ID #:							
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Morning							
Afternoon							
Evening							
By Appt.							
¹ TDD capability? (circle) Y N	² Wheelchair accessible? (circle) Y N			³ 1 block to public transportation? (circle) Y N			

MHS Control No.: RecipientGSPProviderID

Prov. Primary State: RecipientPrimarySiteState



DEMOGRAPHIC INFORMATION FORM

LICENSE INFORMATION

State	Type	Number	Expires

VOLUNTARY INFORMATION

This information is used for referrals and for compliance with Title VI of the 1964 Civil Rights Act. If you provide this information, you are consenting to its use and disclosure to members who request a referral to a provider of a particular gender or ethnic background and to the use of the information on the plan/network's and its clients' Web sites and directories. The information will also be used for statistical and marketing purposes concerning the diversity of the behavioral health provider network.

Gender

Ethnic Background

FORM RETURN INFORMATION

Please complete, sign and return this form to:

**Magellan Health Services, Inc.
 Attn.: Data Management
 14100 Magellan Plaza
 Maryland Heights, MO 63043**

If you have any questions about completing this form, call our Provider Services Line at 1-800-788-4005.

I hereby certify that the information contained in this document is correct and complete. I further understand that any information that is subsequently found to be false could result in termination of any agreement I may enter into or currently have with Magellan and/or affiliated companies.

Signature _____

Date _____

Recipient Name