

**4. Current Practice Location(s)**

This section is to be completed with information about the physical location(s) where this provider currently renders health care services. If this provider operates a mobile facility or portable units, furnish the address of the "Base of Operations," as well as vehicle information and the geographic area serviced by these facilities or units. In addition, cite where this provider wants its payments sent, and where the provider maintains patients' records. If there is more than one practice location, copy and complete this section for each.

**A. Practice Location Information** ☐ Add ☐ Delete ☐ Change **Effective Date:** \_\_\_\_\_

1. Practice Location Name Date Started at this Location  
(MM/DD/YYYY)

2. Practice Location Address Line 1 (Street Name and Number)

Practice Location Address Line 2 Suite, Room, etc.)

City County/Parish State ZIP Code + 4

Telephone Number (Ext.) Fax Number (if applicable) E-mail Address (if applicable)  
( ) ( ) ( )

3. **Hospitals Only:** Is the practice location above an inpatient services practice location? ☐ YES ☐ NO

4. Does this provider: own this practice location? ☐ YES ☐ NO  
lease this practice location? ☐ YES ☐ NO

5. CLIA Number for this location (if applicable) FDA/Radiology (Mammography) Certification Number(s) for this location (if applicable)

6. **HHA's Only:** Is the above practice location a branch office in accordance with 42 CFR 484.2? ☐ YES ☐ NO  
Medicare Identification Number for this Branch Office: \_\_\_\_\_

**B. Mobile Facility and/or Portable Units** ☐ Change **Effective Date:** \_\_\_\_\_

Does this organization furnish health care services from a mobile facility or portable unit? ☐ YES ☐ NO

IF YES, use Sections 4C through 4E to furnish information about the mobile/portable services.

IF NO, proceed to Section 4E (Geographic Location).

**C. Base of Operations Address** ☐ Add ☐ Delete ☐ Change **Effective Date:** \_\_\_\_\_

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored and, when applicable, where vehicles are parked when not in use. See instructions for further examples.

**Check here ☐ and skip to Section 4D if the "Base of Operations" address is the same as the "Practice Location."**

1. Base of Operations Name Date Started at this Location  
(MM/DD/YYYY)

2. Street Address Line 1 (Street Name and Number)

Street Address Line 2 (Suite, Room, etc.)

City County/Parish State ZIP Code + 4

Telephone Number (Ext.) Fax Number (if applicable) E-mail Address (if applicable)  
( ) ( ) ( )

**D. Vehicle Information** ☐ Add ☐ Delete ☐ Change **Effective Date:** \_\_\_\_\_

If the mobile health care services are rendered in a vehicle, such as a mobile home or trailer, furnish the following vehicle information. See the instructions for a full explanation of the types of vehicles that need to be reported. If more than three vehicles are used, copy and complete this section as needed.

1. Type of Vehicle (van, mobile home, trailer, etc.) Vehicle Identification Number

2. Type of Vehicle (van, mobile home, trailer, etc.) Vehicle Identification Number

3. Type of Vehicle (van, mobile home, trailer, etc.) Vehicle Identification Number

**Note: For each vehicle, a copy of all health care related permits/licenses/registrations MUST be submitted.**