

4. Current Practice Location(s)

This section is to be completed with information about the physical location(s) where this supplier currently renders health care services. If this supplier operates a mobile facility or portable units, furnish the address for the "Base of Operations," as well as vehicle information and the geographic area served by these facilities or units. In addition, cite where this supplier wants its payments sent, and where the supplier maintains patients' medical 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. Does this provider:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
own this practice location?	
lease this practice location?	

4. Is this practice location a:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
hospital?	
retirement/assisted living community?	
group practice office/clinic	
other health care facility? (Specify): _____	

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

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

Does this supplier furnish health care services from a mobile facility or portable unit?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

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

IF NO, proceed to Section 4F (Medicare Payment "Pay To" Address).

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 inside 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.