

Attachment C

ADDITIONAL PRACTICE INFORMATION for _____

Payment Address (if different from practice location)

Practice Name		Name*	
Address		Address	
Suite		Suite	
City/State		City/State	
Zip		Zip	
Phone No.		Phone No.	
Fax No.		Contact Person	
Office Day/Hours		Name Affiliated with Tax ID Number	
Contact Person		Tax ID Number	
Total # active patients:	Total # Medi-Cal patients:	Total new Medi-Cal patients you will accept:	

Payment Address (if different from practice location)

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Total # active patients:	Total # Medi-Cal patients:	Total new Medi-Cal patients you will accept:	