DOCTORS CARE®
Accessible Care for the Underserved

Practice Information for Doctors Care Partnership

Date: _____

Practice Name: _____

Specialties offered in this practice: _____

Is this a Primary Care Office? ☐Yes ☐No

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___) _____ Fax: (___) _____

Back Line: (___) _____ Website: _____

Are there any alternate office locations in addition to the above information? ☐Yes ☐No

If yes, please list names and addresses: _____

_____

_____

Spanish Translation offered? ☐Yes ☐No Language Translation Line Available? ☐Yes ☐No

Practice Manager

Name: _____ Email: _____

Direct Phone: (___) _____ Direct Fax: (___) _____

Billing Manager (or billing company)

Name: _____ Email: _____

Direct Phone: (___) _____ Direct Fax: (___) _____

Signature of person completing form: _____ Date: _____