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Children's Community Physicians Association

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# CCPA Practice Billing Information

Practice Name: _____

**Please check all that apply:**

Does your practice use a Billing Company? ☐ YES ☐ NO

Does your practice use a separate administrative address for managed care payment purposes? ☐ YES ☐ NO

If you checked yes to any of the above questions, please complete the requested information below.

**Payment Remittance Address:**

Payee: _____

Billing Address: _____
*City* *State* *ZIP*

**Billing Company Information (if applicable):**

Name of Billing Company: _____

Company Address: _____
*City* *State* *ZIP*

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

Contact if available _____
*Last name* *First Name* *Title*

I represent and warrant that the above information is correct and complete to the best of my knowledge.

_____ _____ _____
Authorizing Signature Type or Print Name Date

**Please attach a copy of your practice's W-9 with the above payment remittance address information and fax to 312.227.9526 or submit with your CCPA application.**