

Provider Communication Information Request

Name _____
Last First Middle Suffix Title

Address _____

Phone _____ Fax _____

How many locations do you practice at? _____

Do you have email and/or internet access at all your locations? _____

Email Address _____

Do you have a website? _____

If yes, would you like it to be linked through our website (www.mccnevada.com) _____

Who is the person in your office responsible for updating your office information and making changes?

Name _____

Position _____

Phone Number _____

Do you currently submit electronic billings? _____

If yes, which services do you use? _____

Would you be interested in electronically submitting directly to MCC? _____