RR MedHealth Consulting & Billing New Client Data Form
Please return to info@rrmedhealthconsulting.com or to our secure fax 727-491-5563
Referred by _____

Supplier (Client) Information

Date business started _____

Supplier (Client)Name _____

Client Physical Address_____

Client City _____ Client State _____ Client Zip Code+4_____

Client Mailing Address_____

Client City _____ Client State _____ Client Zip Code+4 _____

Client Phone_____ Client Fax _____

Client EIN _____ Client NPI _____ Client PTAN _____

Owner Information -For Medicare , State Licenses or insurance applications, we do need your DOB and SS#. *Securely stored*

Owner 1 Name _____ **Owner DOB** _____ **Owner SS** _____ **Mobile** _____

Home Address_____ **City** _____ **State** _____ **ZipCode**_____ **Email Address**_____

Owner 2 Name _____ **Owner DOB** _____ **Owner SS** _____ **Mobile** _____

Home Address_____ **City** _____ **State** _____ **Zip Code**_____

Email Address_____

Accreditation Information

Name of Accrediting Agency_____ Date Accredited_____ Date Expires _____

Hours of Operation (must total 30 hours per week)

	Open	Close	Lunch start	Lunch End
Sunday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Monday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Tuesday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Wednesday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Thursday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Friday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐
Saturday	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐	A ☐ P ☐

Total hours open to the public: _____