



6800 State Route 162
 Maryville, IL 62062
 Phone: 618-391-6141
 Fax: 618-288-2164

Provider Contact Information

Please provide your contact numbers below, in order of preference, for the floors to contact you.

NAME:		
CONTACT NUMBER IN ORDER OF PREFERENCE	TYPE OF NUMBER	SPECIAL INSTRUCTIONS
1.	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	
2.	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	
3.	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	
4.	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	
5.	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	
Contact Number for E-prescribing clarification	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> PAGER <input type="checkbox"/> OFFICE <input type="checkbox"/> EXCHANGE	

<p>PRIMARY OFFICE ADDRESS: (PLEASE NOTE: THIS IS THE ADDRESS MEDICAL RECORD REPORTS WILL BE MAILED TO, IF APPLICABLE)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>OFFICE #: _____</p> <p>FAX #: _____</p> <p>EMAIL ADDRESS:</p>
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Provider Signature: _____ Date: _____