

**Jefferson Regional Medical Center  
Physician Provider Identification Number**

**Physician Name (print):** \_\_\_\_\_

**Group Practice Name (print):** \_\_\_\_\_

**Address - Street:** \_\_\_\_\_

**- City, State, Zip:** \_\_\_\_\_

**(Physician) National Provider Identification Number (NPI):**

\_\_\_\_\_

**(Group) National Provider Identification Number (NPI):**

\_\_\_\_\_

**Office Phone:** \_\_\_\_\_

**Office Facsimile:** \_\_\_\_\_

**Beeper:** \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**Please return form to:**

**Toni Fox  
Jefferson Regional Medical Center  
565 Coal Valley Road  
Pittsburgh, PA 15236**