SUBJECT INFORMATION

the DataB
NATIONAL PRACT
HEALTHCARE INTEGRITY

Subject Information → Output Options → Payment Information → Verify Your Identity

ORGANIZATION SELF-QUERY INSTRUCTIONS

DO NOT PRINT OR NOTARIZE THIS FORM. If required, a printable copy will be made available to you later during the process.

Hide Confidentiality of Information Statement

Confidentiality of Information

Persons and entities that receive confidential information from the Data Bank, either directly or indirectly from another party, must use it solely with respect to the purpose for which it was provided. **Any person who violates the confidentiality provisions of the Data Bank shall be subject to a civil penalty for each violation.**

In compliance with the Privacy Act, the results of an organization self-query are sent only to the organization's address as certified on the self-query form. Health care organizations that obtain information about themselves from the Data Bank are permitted to share that information with anyone they choose.

Hide Public Burden Statement

Public Burden Statement

OMB # 0915-0239 expiration date 05/31/14
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 25 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT INFORMATION Help ?

Organization Information

Organization Name

Add another name used

Click Help ? for information on filling out non-U.S. and military addresses.

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

Country:
(if U.S., leave blank)

Type

Organization Type: CHOOSE ONE FROM LIST

Federal Employer Identification Numbers (FEIN)

Add another FEIN

Social Security Numbers (SSN)

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

Clinical Laboratory Improvement Act (CLIA) Numbers

Add another CLIA Number

Federal Food and Drug Administration (FDA) Numbers

Add another FDA Number

National Provider Identifiers (NPI)

Add another NPI

Medicare Provider/Supplier Numbers

Add another Medicare Provider/Supplier Number

Organization State Licensure Information

(If no State License, check the 'No License' box.)

State License Number: OR ☐ No License

State of Licensure: CHOOSE ONE FROM LIST

Add another License

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 01/30/2013

Continue

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