Locum Tenems Coverage Form

Please complete the boxes below:
Fax back to: 419-998-4716

BOX 1 **Cardinal Provider Information**

Practice Name Covering for (dba): _____

Name of Physician(s) Locum Tenem is Covering for_____

Office Location: _____ Tax ID # _____

_____

Office Contact Person: _____

Billing Address if different from office location: _____ Phone: _____
Street *Ste./Bldg/etc.*

_____ Fax: _____
City/State/Zip

Billing Contact Person: _____

Box 2 **Locum Tenems Information**

Locum Tenems Name _____ Specialty_____

Date Coverage Begins:_____ Date Coverage Ends:_____

Individual NPI#_____ Name on W-9 (legal name): _____
Please include copy of W-9if 1st time covering

BOX 3

Reason for Locum Tenems Coverage _____

BOX 4
Form Completed By: _____Phone # _____ Date _____

ACKNOWLEDGEMENT

By completing and submitting this form, Cardinal Provider acknowledges and agrees that he or she is solely responsible for ensuring that the Locum Tenems physician possesses the appropriate credentials. Therefore, Cardinal Provider agrees to indemnify and hold Cardinal harmless from and against any and all claims (including attorney fees and costs) that arise as a result of or concern allegations that the Locum Tenems physician identified herein did or does not possess the appropriate credentials.