Facility Name:				Facility NPI:			90 day period (MM/DD/YY - MM/DD/YY):		
Patient's First Name	**Patient's Last Name**	**Patient's DOB**	**Patient's Medicaid ID (if applicable)**	**Patient's Social Security Number**	**DOS**	**Rendering Provider NPI**	**Rendering Provider First Name**	**Rendering Provider Last Name**	**Payor Type**