



## NIW/HHS EXCHANGE VISITOR SUPPORT LETTER PHYSICIAN PRACTICE LOCATION TRANSFERS REQUEST FORM

*Only typed forms will be accepted.*

### I. Physician Information:

Name: Last:	First:	Middle:
Email Address:	FL Medical License Number:	
Original Request Year:	USDOS Case #:	
Practice Type ( <b>select only one</b> ):		
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Internal Medicine - General	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Primary Care Hospitalist
<input type="checkbox"/> Specialist (specify):	Subspecialty (if applicable):	

### II. Employer Information:

Employer Name:			
Address:			
City:	State:	Zip:	County:
Email Address:			
Employer Type:	<input type="checkbox"/> For Profit	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Safety Net Provider

### III. Practice Site Information:

<b>Primary Practice Site Location of NIW/HHS Exchange Physician</b>			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ]	<input type="checkbox"/> MUA/P	HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

<b>Secondary Practice Site Location NIW/HHS Exchange Physician</b>			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ]	<input type="checkbox"/> MUA/P	HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

Tertiary Practice Site Location of NIW/HHS Exchange Physician			
Facility/Practice Name:		Weekly Direct Patient Care Hours:	
Address:			
City:	State:	Zip:	County:
Contact Name:		Contact Phone:	
<input type="checkbox"/> HPSA [Score: ] <input type="checkbox"/> MUA/P		HPSA or MUA/P ID Number:	
Majority of Practice Patients Are: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Other (specify):			

Additional Site Locations may be submitted on separate sheet. All location information must be included.

### III. Patient Information:

Provide the total number of active patients with the employer in the previous calendar year, for the specified types of care. If the primary site location is a subset of the employer's practice, please provide the number of active patients at the primary site.

	Primary Care	Specialty Care	Mental Health Care
<b>Employer</b>			
<b>Primary Site Location</b>			

Provide a breakdown of each payer type by patient group for the employer for the previous calendar year.

	Sliding Fee/ Charity Care	Medicaid (including dual eligibles)	Medicare Only	Private Insurance/Other	Total
<b>Pediatric (&lt;18)</b>	%	%	N/A %	%	%
<b>Adult (&gt;18)</b>	%	%	%	%	%

### IV. Assurances:

I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name

\_\_\_\_\_  
Employer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Printed Name

\_\_\_\_\_  
Title

Attorney Contact Information (if applicable):

Name:

Telephone:

E-Mail:

**All request materials should be submitted electronically to: [FL.PCO@flhealth.gov](mailto:FL.PCO@flhealth.gov)**