When sending the request to each plan, please, if possible, include the following information:

Practice Name:	
Contact Name:	
Phone:	
List Providers (Last, First. Middle I. Credential) i.e. Smith, Frank, R, MD (include all billing providers):	
Address:	
NPI:	
TIN:	
Patient Panel Size:	
System Affiliation, if Applicable:	
Information about the request (please list Payer and Line of Business: - Total visits by month (in-person and telemedicine)-CY 2019 - Projected losses in utilization, between March 2020 and September 2020 (in visits by month) - Projected losses in revenue between March 2020 and September 2020 - Funding amount requested/project max on a PMPM basis:	
Other comments or additional Information to support request:	