

CLIENT SERVICES EARLY INTERVENTION & PRE-EXPOSURE PROPHYLAXIS PROGRAM

APPENDIX B – PAGE 1

Please complete one box below for each additional clinic that bills under the contracting Tax ID Number. If more pages are needed, you may copy this page.

ADDITIONAL CLINIC INFORMATION						
Facility Name:						
Facility Address:						
City:		State:			Zip:	
Main Contact Name:		Appoin	ntment Number:			
Email Address:		Clinic	Fax Number:			
Services Offered at this Location:	\Box Medical \Box Laboratory \Box Mental Health \Box Radiologist \Box Vision					
	\Box Dentist \Box Oral Surgeon \Box Denturist \Box Endodontist					

Facility Name:						
Facility Address:						
City:		State:			Zip:	
Main Contact Name:		Appoint	ment Number:			
Email Address:		Clinic Fax Number:				
Services Offered at	□ Medical □ Laboratory □ Mental Health □ Radiologist □ Vision					
this Location:	□ Dentist □ Oral Surgeon □ Denturist □ Endodontist					

Facility Name:						
Facility Address:						
City:		State:			Zip:	
Main Contact Name:		Appointme	ent Number:			
Email Address:		Clinic Fax Number:				
Services Offered at this Location:	□ Medical □ Laboratory □ Mental Health □ Radiologist □ Vision □ Dentist □ Oral Surgeon □ Denturist □ Endodontist					

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