BARBARA ANN Karmanos CANCER INSTITUTE Wayne State University

Physician Communication Program Enrollment Form

Practice Name	
Primary Street Address	
City, State and ZIP Code	
Telephone Number	
Facsimile Number	
Secure[1] E-Mail Address	*Secure Email Not Yet Available*
Office Contact Person	
Physician Name & NPI #s	*Please complete page 2 or attach a list.*

My signature below indicates my desire to enroll the named physicians in the Karmanos Cancer Institute Physician Communication Program. I attest that the practice and enrolled physicians agree to abide by the conditions of the program as set forth below and as they may be amended from time to time.

Terms and Conditions: Karmanos Cancer Institute created the Physician Communication Program for the benefit of Karmanos patients and their referring physicians. The enrolling physician(s) agree(s) to keep the information requested above current. The physician(s) also agree(s) that they will immediately notify Karmanos in the event they receive information concerning a patient with whom they do not have a treating relationship. The enrolling physician(s) agree(s) to participate in all fax-testing procedures, which may be required of them to assure accuracy in the transmittal of information.

Authorized Representative: _____ Date: _____

Please return this form to the Karmanos Referring Physician Office		
		
Electronic Mail	Postal Mail	Facsimile
refer@karmanos.org	Karmanos Cancer Institute Referring Physician Office 4100 John R Street LA04CE Detroit, MI 48201	(313) 576-9827

Questions?

Karmanos Referring Physician Hotline
(877) KARMANOS
(877) 527-6266

[1] Secure e-mail address must be HIPPA-compliant.

Practice Name	

Physician Full Name	NPI Number