COMPASSIONATE CARE NETWORK (CCN)

6348 N. Milwaukee Ave, # 215, Chicago, IL 60646. Tel. (773) 775-3600 Fax 888 226-6363

Provider Agreement

____ Yes I am willing to join the Compassionate Care Network and help. I understand that this is only to provide non urgent office services for the uninsured. I agree to charge no more than $25.00 for the office visit (primary care consultation) or $35.00 (specialist consultation). I will be able to separately bill the patient for labs and imaging services in addition to this . If I dispense medications in my office I would be able to charge the patient, for them separately as well.

Add me to the CCN provider list.

Signature ____ Date___________________________

Name ____

Address____

Tel. _________________________ Fax_______________________________________

Specialty ___________________________ Board Certified Yes_______ No_________

Hospital Privileges at : ____

Email ____

Office Manager____