Audrain County Health Department

Healthcare Provider Submission Form

Organization/Practice Name *

Contact Name *

First Name Last Name

Main Address *

Street Address

Street Address Line 2

City State

Zip Code

Additional Office Locations (Full Address please).

Main Phone Number *

Please enter a valid phone number.

Website Address

Provider Name(s) and Specialties *

List the primary services your organization/practice provides to the residents of Audrain County. *

What insurance/payment plans do you accept? *

Does your practice accept Medicaid patients? *

- ◯ Yes
- ◯ No

Does your practice accept Medicare patients? *

- ◯ Yes
- ◯ No