APPENDIX A-7a

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID

MEDICAID SYSTEM (MMIS)
PROVIDER SUBSYSTEM
REPORT ID: A2741KD1
SEQUENCE: PROVIDER TYPE
PROVIDER NAME

PROVIDER INFORMATION SHEET

RUN DATE: 11/02/96
RUN TIME: 11:47:06
MAINT DATE: 11/02/96
PAGE: 84

(1) --PROVIDER KEY--
036999999

(2) PROVIDER NAME AND ADDRESS
JOHNSON ALBERT
1421 OAK STREET
ANYTOWN, IL 62000

(3) PROVIDER TYPE: 10 - PHYSICIAN
(4) ORGANIZATION TYPE: 01 - INDIVIDUAL PRACT
(5) ENROLLMENT STATUS B - ACTIVNOCST (6) BEGIN 08/15/86 (7) END ACTIVE
(8) EXCEPTION INDICATOR - NO EXCEPT (9) BEGIN (10) END
(13) AGR: YES

PROVIDER GENDER:
(11) CERTIFIC/LICENSE NUM - 036999999 (12) ENDING 07/31/99
(17) COUNTY 200-COOK
(14) UPIN #:
(18) TELEPHONE NUMBER: (312)123-4567 (20) LAST TRANSACTION ADD (21) AS OF 04/24/90 (15) S.S. #: 331313131
(19) D.E.A.#: AA1234567
(16) CLIA #:

(22) MANAGED CARE INFORMATION: BEGIN DATE: 07/13/1993

(23) SITE 1 : (24) PAYEE : 1 1421 OAK STREET ANYTOWN IL 62000 TELEPHONE NUMBER: (312) 123-4567
FAX NUMBER: (000) 000-0000

(25) CODE SPECIALTY	(26) BEGIN	(25) CODE SPECIALTY	(26) BEGIN	(25) CODE SPECIALTY	(26) BEGIN
OBG-OBSTETRICS - GYNECOLOGY	01/01/81	DAP-ADMITTING PRIVILEGES	01/01/92	DPX-DELIVERY PRIVILEGES	01/01/91

COS	(27) ELIGIBILITY CATEGORY OF SERVICE	(28) ELIG BEG DATE	COS	(27) ELIGIBILITY CATEGORY OF SERVICE	(28) ELIG BEG DATE	(29) TERMINATION REASON
01	PHYSICIAN SERVICES	8/15/86	06	PHYSICIAN PSYCHIATRIC SERVICES	08/15/86	
17	ANESTHESIA SERVICES	8/15/86	30	MEDICHEK SCREENING SERVICES	08/15/86	
45	OPTICAL SUPPLIES	8/15/86				

(30) PAYEE CODE	(31) PAYEE NAME	(32) PAYEE STREET	(33) PAYEE CITY	(34) ST	(35) ZIP	(36) PAYEE ID NUMBER	(37) DMERC#	(39) EFF DATE
1	ANYTOWN MEDICAL ASSOC	1421 OAK ST	ANYTOWN	IL	62000	363106080-62000-01		08/01/96
	DBA:					VENDOR ID: 01		
	(38) MEDICARE/PIN: 615731/L31541							
2	ALBERT JOHNSON	907 NORTH ELM ST	DOWNTOWN	IL	62001	448449827-62001-02		12/03/86
	DBA:					VENDOR ID:30		
	MEDICARE/PIN: 615730/							
3	ANYTOWN NATIONAL BANK	110 CEDAR LANE	ANYTOWN	IL	62000	448449827-62000-02		03/12/90
	DBA:					VENDOR ID:30		
	MEDICARE/PIN:							

**********PLEASE NOTE:**********

ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____ X_____