



FACILITY INFORMATION FORM

IDENTIFICATION INFORMATION		
FACILITY NAME 		
FACILITY TYPE (HOSPITAL, HOME HEALTH, DME, ETC) 	TAX ID NUMBER 	
PRIMARY LOCATION ADDRESS 		
LOCATION PHONE NUMBER 	LOCATION FAX 	
CORRESPONDENCE ADDRESS 		
BILLING ADDRESS 		
***ADDITIONAL PAGE MAY BE ADDED TO PROVIDE ADDITIONAL SERVICE LOCATION INFORMATION		
CONTACT INFORMATION		
CREDENTIALING CONTACT NAME 	CREDENTIALING CONTACT PHONE 	CREDENTIALING CONTACT EMAIL
MAIN FACILITY CONTACT NAME 	MAIN FACILITY CONTACT PHONE 	MAIN FACILITY CONTACT EMAIL
BILLING CONTACT NAME 	BILLING CONTACT PHONE 	BILLING CONTACT EMAIL
ADDITIONAL INFORMATION		
If your facility employs physicians please provide a full roster of those physicians		
If your facility provides any ancillary services please provide a complete listing of the services provided		



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ADDITIONAL SERVICE LOCATION INFORMATION	
FACILITY NAME 	TAX ID NUMBER
ADDITIONAL LOCATION ADDRESS 	
LOCATION PHONE NUMBER 	LOCATION FAX
CORRESPONDENCE ADDRESS 	
BILLING ADDRESS 	
ADDITIONAL SERVICE LOCATION INFORMATION	
FACILITY NAME 	TAX ID NUMBER
ADDITIONAL LOCATION ADDRESS 	
LOCATION PHONE NUMBER 	LOCATION FAX
CORRESPONDENCE ADDRESS 	
BILLING ADDRESS 	