

MEMO:

Network Health Plan Facility Information Form

W-9 MUST BE INCLUDED WITH FACILITY INFORMATION FORM

LOCATION NAME	
ADDRESS	
CITY	
STATE	
ZIP CODE	
COUNTY	
GENERAL PHONE NUMBER	
MEDICARE CERTIFICATION #	
NUMBER OF STAFFED MEDICARE CERTIFIED BEDS	
NPI#	
CAN FACILITY RECEIVE MAIL AT THIS ADDRESS	YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NO WHERE SHOULD MAIL BE SENT? NAME	
ADDRESS	
CITY	
STATE	
ZIP CODE	
PHONE	
FAX	
E-MAIL ADDRESS	
URL (WEBSITE) ADDRESS	

PLEASE FILL OUT ADDITIONAL FORM FOR EACH LOCATION

REMIT INFORMATION	
EXACT NAME/TITLE ON 1099 TAX FORM	
FEDERAL TAX IDENTIFICATION	
REMIT TO NAME	
REMIT TO ADDRESS	
REMIT TO CITY	
REMIT TO STATE	
REMIT TO ZIP CODE	
REMIT TO PHONE NUMBER	

NAME AND ADDRESS TO SEND NHP CREDENTIALING APPLICATION :

NAME:	
ADDRESS	
CITY, STATE ZIP	
PHONE #	
E-MAIL ADDRESS	

NAME AND TITLE OF PERSON LEGALLY AUTHORIZED TO SIGN CONTRACT	
ADDRESS TO SEND AGREEMENT	
PHONE AND E-MAIL	

For Contractor Administrator Use Only KK LJ
 HMO/POS PPO MED PPO

Please assist us with keeping you information accurate by contacting Provider Data Services with changes: provdatasvs@networkhealth.com
 920/720-1565 800/945-1178 fax 920/720-1917 Website: www.networkhealth.com

The medical specialties/Services listed below are recognized by Network Health Plan and Network Health Insurance Corporation (NHP/NHIC). Please indicate which specialties/services are available at your facility by checking the appropriate box. NHP/NHIC specialty credentials will be granted consistent with the criteria established by the Credentialing Committee.

* Will not appear in NHP/NHIC directories.

PLEASE RETURN THIS FORM WITH THE ATTACHED COMPLETED FACILITY INFORMATION FORM

Specialty/Service Description	
Ambulance Service *	<input type="checkbox"/>
Ambulatory Surgery Center	<input type="checkbox"/>
Arrhythmia Monitoring/Cardiac Monitoring	<input type="checkbox"/>
Audiology	<input type="checkbox"/>
Behavioral Health Facility	<input type="checkbox"/>
Breast Prosthetics	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>
Drug and Alcohol Facility	<input type="checkbox"/>
Durable Medical Equipment	<input type="checkbox"/>
EEG & Sleep Studies – Remote	<input type="checkbox"/>
Fitness Center	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>
Home Health Care	<input type="checkbox"/>
Home Infusion	<input type="checkbox"/>
Hospice	<input type="checkbox"/>
Hospital	<input type="checkbox"/>
Hospital Based Urgent Care	<input type="checkbox"/>
Laboratory *	<input type="checkbox"/>
Mammography Facility	<input type="checkbox"/>
Magnetic Resonance Imaging	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Occupational Therapy - Child & Adolescent *	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Physical Therapy - Child & Adolescent *	<input type="checkbox"/>
Prosthetics / Orthotics	<input type="checkbox"/>
Rehabilitation Facility	<input type="checkbox"/>
Skilled Nursing Facility	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Speech Therapy - Child & Adolescent *	<input type="checkbox"/>
Transitional Rehabilitation Unit	<input type="checkbox"/>
Urgent Care Services (Facility)	<input type="checkbox"/>
Wound Vac Therapy	<input type="checkbox"/>