FACILITY APPLICATION

Part 1. Participating Facility Profile (please print)

PARTICIPATING FACILITY:

Contact Name: ______________________________ Contact Phone Number: ____________

Facility Name for Directory: ______________________ Main Telephone Number: ____________

Full Legal Name of Facility:____

Street Address: ______________________________ Fax Number: ________________

City/State/Zip: ______________________________ Federal Tax ID Number: ____________

Legal name under which Tax ID Number is filed:__________________________________

Type of Facility: **Handicap Accessible: ☐Yes ☐ No**

☐ Laboratory ☐ Radiology ☐ Surgicenter ☐ PT/OT ☐ Dialysis Center ☐ PET Scan

☐ Urgent Care Facility ☐ Sleep Diagnostic Center ☐ Lithotripsy ☐ Pain Clinic

☐ Family Planning Center ☐ Diagnostic Medicine ☐ Cardiac Rehabilitation

☐ Cancer Center ☐ Other ______________________________________

Day Treatment Ctr – Choose One: ☐ Psych Only ☐ Chemical Dependency Only ☐ Psych & CD

Residential Treatment Ctr – Choose One: ☐ Psych Only ☐ Chemical Dependency Only ☐ Psych & CD

BILLING LOCATION:

Street Address:____

City/State/Zip:____

Telephone Number:____

ADDITIONAL LOCATION OR AFFILIATE: (*Attach a separate sheet for additional locations.*)

Facility Name for Directory: ______________________ Main Telephone Number: ____________

Full Legal Name of Facility:____

Street Address: ______________________________ Fax Number: ________________

City/State/Zip: ______________________________ Federal Tax ID Number: ____________

Legal name under which Tax ID Number is filed:__________________________________

Type of Facility: **Handicap Accessible: ☐Yes ☐ No**

☐ Laboratory ☐ Radiology ☐ Surgicenter ☐ PT/OT ☐ Dialysis Center ☐ PET Scan

☐ Urgent Care Facility ☐ Sleep Diagnostic Center ☐ Lithotripsy ☐ Pain Clinic

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☐ Cancer Center ☐ Other ______________________________________

Day Treatment Ctr – Choose One: ☐ Psych Only ☐ Chemical Dependency Only ☐ Psych & CD

Residential Treatment Ctr – Choose One: ☐ Psych Only ☐ Chemical Dependency Only ☐ Psych & CD

BILLING LOCATION:

Street Address:____

City/State/Zip:____

Telephone Number:____

Part II. Credentials

A. Does your facility have the following documents and valid credentials?

1. Appropriate license(s) for state/municipality in which facility is located.
   ☐ Yes ☐ No **If "Yes," please attach copy of license.**

2. General and professional liability/malpractice insurance as required by law.
   ☐ Yes ☐ No **If "Yes," please attach copy of face sheet.**

3. Check all appropriate certifications that apply. **Please attach copy(ies).**
   ☐ JCAHO
   ☐ American Osteopathic Association
   ☐ Medicare
   ☐ Other: ______________________________

4. Proof that services at facility are within range of those expected to be provided (e.g., list of services offered) to include type of procedure, number of procedures and procedure codes.
   ☐ Yes ☐ No **If "Yes," please attach copy of information.**

5. Copy of W-9 for Legal name under which Tax ID Number is filed.
   ☐ Yes ☐ No **If "Yes," please attach copy of information**

B. If any "No" answers above, please explain:

____

____

Part III. Contact Person

Please provide contact name and telephone number for questions regarding ongoing network updates.

Name: ___________________________________ Telephone Number: ______________________

Part IV. Attestation

I attest that the credentials listed in Part II of this Application are currently in effect and verifiable. Furthermore, I warrant that I have authorization from the Facility to apply to the PPO USA Network on its behalf.

______________________________	______________________________
Signature of Company Officer	Telephone Number
______________________________	______________________________
Type or print name of Company Officer	Fax Number
______________________________	______________________________
Title	Date of Signature