

Provider information

Legal name (as it appears on Tax ID form)		Provider ID	
Doing Business As		NPI #	
Street Address	City	State	Zip
Telephone	Fax	E-mail	

Additional Required Information

1. Type of Payee (Check one)

<input type="checkbox"/> City	<input type="checkbox"/> County	<input type="checkbox"/> District	<input type="checkbox"/> State	<input type="checkbox"/> Federal
<input type="checkbox"/> Voluntary Non-Profit – Non-Proprietary		<input type="checkbox"/> Individual, Partnership, Corporation-Proprietary		

2. Fiscal Year End 3. License Number 4. Medicare/CCN No. (If applicable)

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5. Class of Care and Number of Certified Beds (Be sure to state number of certified beds in categories below)

<input type="checkbox"/> Acute Inpatient No _____	<input type="checkbox"/> Psych Inpatient No _____	<input type="checkbox"/> Psych Residential (RTC)	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Bassinet No _____	<input type="checkbox"/> Psych Outpatient	<input type="checkbox"/> Other (Specify) _____	
<input type="checkbox"/> General Outpatient	<input type="checkbox"/> Psych Day Treatment	<input type="checkbox"/> Rehab Inpatient No _____	

Comments

Signatures and Dates

I certify the information on this form is true, accurate, and complete.

Provider Representative Signature (Stamped signature NOT accepted)	Date
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FOR MEDICAID USE ONLY

Acute Inpatient _____	Peer Group _____	Effective Date _____
Psych Inpatient _____	Peer Group _____	Effective Date _____
Rehab Inpatient _____	Peer Group _____	Effective Date _____
Outpatient _____	Peer Group _____	Effective Date _____

Agency Staff _____ **Date** _____