

Provider Services Application/ Ancillary Services

Part 1: Participating Facility Profile (please print)

PARTICIPATING FACILITY:

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: _____

Contact Name: _____

Contact Phone Number: _____

Contact Email Address: _____

Type of Facility:

- Ambulatory Surgery Center Cancer Center Cardiac Rehabilitation
 Diagnostic Imaging Dialysis Center Durable Medical Equipment
 Home Health Agency Hospice Hospital Laboratory Lithotripsy
 Pain Clinic PET Scan Pharmacy PT/OT Radiology
 Skilled Nursing Facility Sleep Diagnostic Center Surgicenter
 Urgent Care Facility Walk-in Clinic
 Other

Day Treatment Ctr – Psych Only Chemical Dependency Only

Psych & CD (Choose One)

Residential Treatment Ctr – Psych Only Chemical Dependency Only

Psych & CD (Choose One)

Handicap Accessible: Yes No

BILLING LOCATION:

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

ADDITIONAL LOCATION OR AFFILIATE:(Attach a separate sheet)

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: _____

Contact Name: _____

Contact Phone Number: _____

Contact Email Address: _____

Type of Facility:

- Ambulatory Surgery Center Cancer Center Cardiac Rehabilitation
- Diagnostic Imaging Dialysis Center Durable Medical Equipment
- Home Health Agency Hospice Hospital Laboratory Lithotripsy
- Pain Clinic PET Scan Pharmacy PT/OT Radiology
- Skilled Nursing Facility Sleep Diagnostic Center Surgicenter
- Urgent Care Facility Walk-in Clinic
- Other

Day Treatment Ctr – Psych Only Chemical Dependency Only

Psych & CD (Choose One)

Residential Treatment Ctr – Psych Only Chemical Dependency Only

Psych & CD (Choose One)

Handicap Accessible: Yes No

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(#): _____

CHAP: _____

AAAHC: _____

CARF: _____

ACHA: _____

HFAP/AOA: _____

Other: _____

Other: _____

Other: _____

4. Advance Direct Policy for Hospitals

If "Hospital" please attach copy of information policies.

CMS Audit: if applicable, please attach information.

5. Attach roster of provided services including average volume on annual basis including procedures and codes.

Yes No If "Yes," please attach copy of information.

6. Copy of W-9 for Legal name under which Tax ID Number is filed.

Yes No If "Yes," please attach copy of information

7. Does your Facility collect the following credentialing information on Employees when they are initially hired? Yes No

- Medical License
- DEA License
- CDS/CSA License
- Malpractice Insurance

8. Does your Facility Re-credential your employees every 3 years and collect the credentials listed above? Yes No

B. If any "No" answers above, please explain (if there is not enough room please address on a separate letter:

Part III. Contact Person

Please provide contact name and telephone number for network updates.

Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Part IV. Attestation

I attest and certify that I have answered the above application questions truthfully and that information given in or attached to this application is accurate and completed to the best of my knowledge. I understand that, as a condition to making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with Devon Health Services, Inc.

Signature: _____

Date: _____

Printed Name and Title: _____