

PROVIDER CREDENTIALING APPLICATION

PROVIDER NAME:

DBA:

Address:

Telephone :

Fax:

Agency Contact Information

<u>Title</u>	<u>Name</u>	<u>Phone</u>	<u>Ext.</u>	<u>Fax</u>	<u>Email Address</u>	<u>Primary Contact</u>
Administrator:						<input type="checkbox"/>
Director of Nursing:						<input type="checkbox"/>
Other Additional Contacts						<input type="checkbox"/>
Other Additional Contacts						<input type="checkbox"/>

Hours of Operation:

Federal Tax I.D. Number:

COVERAGE AREAS (Please document all counties your facility services)

County	State	County	State

LICENSURE (Please submit copies of each certificate per location)

State/ County License #

State/ County License #

Medicare Certification #

Medicaid Certification #

ACCREDITATION (Submit all certificates per location of most recent survey where applicable: HCFA, JCAHO, CHAP)

Accrediting organization:

Expiration date:

Accrediting organization:

Expiration date: