

Insurance and Payer Information

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|----|---|------------|-----------|
| 6. | Do you accept assignment under Part B of Medicare?
Provider Number: _____ Effective Date(s) _____ | Yes | No |
| 7. | Do you accept Medicaid patients?
Medicaid Number: _____ Effective Date(s) _____ | Yes | No |
| 8. | Do you provide a reduced fee or sliding fee scale program policy for uninsured or self-pay patients based on income and family size? (If yes, please attach a copy of the fee schedule.)
_____ | Yes | No |

Sponsor Description

9. Years Providing Patient Care Services: _____
10. Scope of Services: _____

Please briefly describe the scope of medical and health care services provided.

11. Patient Referrals

Please briefly describe the referral networks or relationships with primary care providers, secondary and tertiary care providers.

For specialist care: **Yes** **No**

Do you accept referrals from providers outside of the healthcare system?

Do you accept Medicare and Medicaid referrals from Federally Qualified Health Centers (FQHCs)?

Do you accept referrals from the Indian Health Service (IHS) and/or tribal facilities?

I certify that the information provided on this Employer Data Information Form is truthful, complete and accurate to the best of my knowledge.

Signature (Head of Sponsoring Employer or designee)

Signator's printed name

Title

Date