

NETWORK FACILITY ADDITIONAL LOCATION FORM

Facility Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ NPI#: \_\_\_\_\_

(Attach a completed W-9 Form for each TIN)

PHYSICAL ADDRESS

Address: \_\_\_\_\_

(City)

(State)

(Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_

MAILING ADDRESS

Address: \_\_\_\_\_

(City)

(State)

(Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_

BILLING ADDRESS

Billing Name (must match claims): \_\_\_\_\_

Address: \_\_\_\_\_

(City)

(State)

(Zip)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

FACILITY CONTACTS:

CEO/Administrator Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Contracting/Managed Care Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 11.1 of the facility contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents.

(Attach a completed W-9 Form for each TIN, an EFT form with a voided check or bank letter, ERA Form, Medicare Certification and/or Accreditation, if applicable.)

RETURN FAX NUMBERS:

405-717-8977 or 405-717-8702

Email Addresses: EGID.NetworkManagement@omes.ok.gov or

EGID.NetworkNews@omes.ok.gov