HealthChoice IDRS Oklahoma Department of Rehabilitation Services DOC Department of Corrections Oklahoma

NETWORK FACILITY ADDITIONAL LOCATION FORM

Facility Name:_____

Specialty:_____ Medicare Number:_____

Federal Tax ID Number:_____ NPI#:_____

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

PHYSICIAL 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:_____

Effective Date:_____

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, 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