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

NETWORK PROVIDER ADDITIONAL LOCATION FORM

Name: _____ _____ _____ _____
(Last) (First) (Middle) (License Type)

NPI Number: _____

Primary Specialty: _____ Secondary Specialty: _____

Federal Tax ID Number: _____

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

PHYSICIAL ADDRESS

Office Name: _____

Office Address: _____

_____ _____ _____
(City) (State) (ZIP)

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

MAILING ADDRESS

Office Name: _____

Mailing Address: _____

_____
(City) (State) (ZIP)

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

BILLING NAME and ADDRESS – Billing name and address must match the claims name and address

Billing Name (must match claims): _____

Billing Address: _____

_____ _____ _____
(City) (State) (ZIP)

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

Effective Date: _____

Authorized Signature: _____ **Date:** _____

Contact Name: _____ **Phone:** _____

Office Mailing Address, if listed, will be utilized for all legal contractual notices as defined in section 12.2 of the provider contracts and for all credentialing notices/documents. Claims Payment Address, if listed, will be used for all payment related notices/documents.

Return Fax Numbers: 405-717-8977 or 405-717-8702
Email Address: EGID.NetworkManagement@omes.ok.gov

Updated 04/11/2018