



Facility Information Form

Please fill out the following information so we can pay your claims accurately.

Date Completed: _____

Name of Facility: _____

Physical Address: _____

Mailing Address: _____

Office Phone for member calls: _____

This information is NOT published

Office Manager: _____

Office Manager phone number: _____

Fax number: _____

E-mail Address: *(for newsletters or bulletins)* _____

Billing Information

Facility Tax Identification Number: _____

Box 31 of CMS 1500: _____

National Provider Identification (NPI) #: _____

Claims will be sent on a *(please circle one)*:

UB04

CMS 1500

Box 33 of CMS 1500 or Box 2 on UB04:

Check should be addressed to: _____

Address for sending checks: _____

National Provider Identification (NPI) #: _____

If you have multiple locations, please copy and complete one form for each location or facility address.