



Request to Establish or Revise a Non-Contracted Facility Record

Please check one:

Establishing a new facility record

Please complete the entire form.

Revising an existing facility record

Please provide your name, any information that you wish to change, and your signature.

Facility Name: _____

Specialty (any limitations to practice, e.g., substance abuse only, MRI only): _____

What is the facility licensed as? _____

Federal Tax ID # (TIN or EIN): _____ (If TIN change, effective date of new TIN) _____

*Type 2 Individual NPI (National Provider Identifier) #: _____

Physical Address:

Business or Group Name: _____

Street Name: _____

City, State, Zip: _____ *Effective Date: _____

Phone: _____ Fax: _____

Note: Please attach a separate sheet for any additional locations.

Mailing Address:

Business or Group Name: _____

Street Name: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Billing Address:

Business or Group Name: _____

Street Name: _____

City, State, Zip: _____

Phone: _____ Fax: _____

*Make Payment Payable to: _____

*Federal Tax ID #: _____ *IRS Legal Entity Name: _____

NOTE: Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) must be reported exactly as recorded with the IRS.
Please complete and return the IRS 147C letter with this questionnaire.

Signature of person completing this form

Date

Phone No.

*REQUIRED FIELDS