INTERESTED PROVIDER FORM

Provider Name:_____

Legal Name:_____ TIN:_____

Address:_____

_____

Telephone: _____ Fax: _____

Email address: _____ Number of locations: _____

Administrator:_____

Director of Nursing: _____

Contract to be signed by: _____

Geographical areas your staff covers (please list all counties; attach a list if necessary):

_____

_____

_____

Medicare Certified: ☐Yes, ☐ No; if yes Medicare number: _____

Medicaid Licensed: ☐Yes, ☐ No; if yes Medicaid number: _____

Please check the services you provide: Adult ☐ Pediatric ☐ OB☐

Home Health Care ☐ DME ☐ Home Infusion Pharmacy ☐ Other (please describe) ☐

_____

_____

Please fax completed form to the attention of:

Andrew Bossie

Fax: 952-983-5265