Facility/ancillary/long-term care provider application

Provider identification	
Legal business name:	
Doing business as (if applicable):	
Credentialing Contact:	Credentialing Contact Email:
Credentialing Contact Phone:	Secure Fax:
Alternative Contact:	Alternative Contact Phone:
TIN:	NPI:
Taxonomy:	EMR:
API:	
Long-term care vendor number:	
DADS/DARS Contract #:	

Primary office/service address (Please submit Additional Locations Addendum for all other locations.)			
Practice location name:			
Medicaid Number/TPI:	Medicare ID:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	
Administrator (full name):			
Does provider bill from this address?	☐ Yes ☐ No		

Billing information (if different than above)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

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Correspondence Address			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Primary office	Office Hours (AM-PM)
Monday:	
Tuesday:	
Wednesday:	
Thursday:	
Friday:	
Saturday:	
Sunday:	

Age of patients served:

☐ Newborn ☐ Adolescents (13-18 years)
☐ Preschool (3 to 5 years) ☐ Adults
☐ Children (6-12 years) ☐ Geriatrics (65+ years)

Please indicate any age limitations: ____________________

Patient program/population served:

☐ Serves intellectual or developmental disability (IDD) population
☐ Services pediatric population

Please indicate any gender limitations: ____________________

Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No ☐ N/A

Check all that apply:

Handicap accessible: ☐ Building ☐ Parking ☐ Restroom
Services for the disabled: ☐ Text telephone ☐ American Sign Language ☐ Mental/physical imp.
Accessible by public transportation: ☐ Bus/Taxi ☐ Subway ☐ Regional train

Do you use Electronic Health Records? ☐ Yes ☐ No ☐ N/A

If No, when might you start? ____________________

Electronic Claim Submission? ☐ Yes ☐ No ☐ N/A

Does business have internet access? ☐ Yes ☐ No ☐ N/A

If Yes, please check all that apply: ☐ Sign Language ☐ TTD/TTY ☐ None

Identify any foreign language(s) that are spoken other than English: ☐ Arabic ☐ Hindi ☐ Russian ☐ Chinese
☐ Italian ☐ Spanish ☐ Farsi ☐ Japanese ☐ Sign Language ☐ French ☐ Korean ☐ Tagalog
☐ German ☐ Laotian ☐ Vietnamese ☐ Hebrew ☐ Portuguese ☐ Other (specify) ____________________

Other Information. If entry is not applicable please enter “N/A” (not applicable).

Do you have Emergency Room Capabilities? ☐ Yes ☐ No ☐ N/A

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Average case load per day ______ ☐ N/A

Maximum capacity caseloads per day ______ ☐ N/A

What is your occupancy rate? ______ ☐ N/A

Unique Services you currently offer to your Medicaid patients: ____

____

After hours coverage yes/no, If yes:

Answering Service ☐ Yes ☐ No

Automated Message ☐ Yes ☐ No

On-Call Staff ☐ Yes ☐ No