

Facility Information Form

Please contact Provider Relations for questions while completing this form.
Phone: (877) 372-6200 or
e-mail: provider.contracting@fidelissc.com

Provider Type:

- | | | |
|--|---|---|
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Ancillary | <input type="checkbox"/> Assisted Living Facility |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Transportation |

Service Counties:

- | | | | | | |
|----------------------------------|----------------------------------|------------------------------------|-----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Allegan | <input type="checkbox"/> Genesee | <input type="checkbox"/> Kalamazoo | <input type="checkbox"/> Macomb | <input type="checkbox"/> Oakland | <input type="checkbox"/> Washtenaw |
| <input type="checkbox"/> Bay | <input type="checkbox"/> Jackson | <input type="checkbox"/> Kent | <input type="checkbox"/> Muskegon | <input type="checkbox"/> Saginaw | <input type="checkbox"/> Wayne |

Services Provided:

- | | |
|---|---|
| <input type="checkbox"/> Acute Inpatient Hospital Care | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Diagnostic & Therapeutic Radiology | <input type="checkbox"/> Renal Dialysis (Outpatient) |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Skilled Nursing |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Surgical Services Outpatient/
Ambulatory) |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy (Outpatient) |
| <input type="checkbox"/> Lab | <input type="checkbox"/> Physical Therapy (Outpatient) |
| <input type="checkbox"/> Mental Health (Inpatient) | <input type="checkbox"/> Speech Therapy (Outpatient) |
| <input type="checkbox"/> Mental Health (Outpatient) | |

Transplants:

- | |
|-------------------------------------|
| <input type="checkbox"/> Heart |
| <input type="checkbox"/> Intestinal |
| <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Liver |
| <input type="checkbox"/> Lung |
| <input type="checkbox"/> Pancreas |

Location: _____	Type: Primary or Remittance	Directory Listing: Y or N
Name: _____	(dba): _____	Tax ID: _____
Address: _____	Phone: _____ Fax: _____	NPI: _____
	Office Contact: _____	Medicare ID: _____
Billing Contact: _____	E-Mail: _____	Medicaid ID: _____

Location: _____	Type: Remit To	
Name: _____	(dba): _____	Tax ID: _____
Address: _____	Phone: _____ Fax: _____	NPI: _____
	Office Contact: _____	Medicare ID: _____
Billing Contact: _____	E-Mail: _____	Medicaid ID: _____

Location: _____	Type: Primary or Alternate	Directory Listing: Y or N
Name: _____	(dba): _____	Tax ID: _____
Address: _____	Phone: _____ Fax: _____	NPI: _____
	Office Contact: _____	Medicare ID: _____
Billing Contact: _____	E-Mail: _____	Medicaid ID: _____

Location: _____	Type: Primary or Alternate	Directory Listing: Y or N
Name: _____	(dba): _____	Tax ID: _____
Address: _____	Phone: _____ Fax: _____	NPI: _____
	Office Contact: _____	Medicare ID: _____
Billing Contact: _____	E-Mail: _____	Medicaid ID: _____

Credentialing Questionnaire: (answering unfavorably will not automatically disclude you from our network)

Are you licensed with no restrictions? Y or N *If no, please explain* _____

Any sanctions by State or Federal Agencies? Y or N *If yes, please explain* _____

Do you carry Accreditation Status? Y or N *If yes, Accrediting Agency:* _____ *Expires:* _____

Are you able to participate with Medicare? Y or N *If no, please explain* _____

Credentialing Documents to Attach (please provide copies)

____ State License ____ Current W-9 ____ Certificate of Liability Insurance ____ Copy of Accreditation ____ Other: _____

Completed By: _____

Title: _____ **Date:** _____

Please return completed form to: Provider Relations
Fax: (866) 852-3141
e-mail: provider.contracting@fidelissc.com
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Livonia, MI 48152-2694