Facility Information Form

Please contact Provider Relations for questions while completing this form.
e-mail: provider.contracting@fidelissc.com

Provider Type:

- ❒ Ambulatory Surgery Center
- ❒ Hospital
- ❒ Ancillary
- ❒ Skilled Nursing Facility
- ❒ Assisted Living Facility
- ❒ Transportation

Service Counties:

- ❒ Allegan
- ❒ Bay
- ❒ Genesee
- ❒ Jackson
- ❒ Kalamazoo
- ❒ Kent
- ❒ Macomb
- ❒ Muskegon
- ❒ Oakland
- ❒ Saginaw
- ❒ Washtenaw
- ❒ Wayne

Services Provided:

- ❒ Acute Inpatient Hospital Care
- ❒ Diagnostic & Therapeutic Radiology
- ❒ Durable Medical Equipment
- ❒ Prosthetics and Orthotics
- ❒ Home Health
- ❒ Lab
- ❒ Mental Health (Inpatient)
- ❒ Mental Health (Outpatient)
- ❒ Mammography
- ❒ Renal Dialysis (Outpatient)
- ❒ Skilled Nursing
- ❒ Surgical Services (Outpatient/ Ambulatory)
- ❒ Occupational Therapy (Outpatient)
- ❒ Physical Therapy (Outpatient)
- ❒ Speech Therapy (Outpatient)
- ❒ Other: ___________________________

Transplants:

- ❒ Heart
- ❒ Intestinal
- ❒ Kidney
- ❒ Liver
- ❒ Lung
- ❒ Pancreas

Primary Location: **Directory Listing: Y or N**

Name: ____ **(dba):** ____

Address: ____ **Office Contact:** ____

____ **Tax ID:** ____________________ **NPI:** _______________________

Phone: ______________________ **Fax:** _____________________ **Medicare ID:** _________________ **Medicaid ID:** ______________

Remittance Location:

Address: ____ **Phone:** ______________________ **Fax:** ______________________

____ **E-Mail:** ____

Billing Contact: ______________________________ **Phone:** _______________________

Alternate Location: **Directory Listing: Y or N**

Name: ____ **(dba):** ____

Address: ____ **Office Contact:** ____

____ **Tax ID:** ____________________ **NPI:** _______________________

Phone: ______________________ **Fax:** _____________________ **Medicare ID:** _________________ **Medicaid ID:** ______________

Alternate Location: **Directory Listing: Y or N**

Name: ____ **(dba):** ____

Address: ____ **Office Contact:** ____

____ **Tax ID:** ____________________ **NPI:** _______________________

Phone: ______________________ **Fax:** _____________________ **Medicare ID:** _________________ **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*** ____

Attached Credentialing Documents (***please provide current copies, if applicable)***

State License: ____ **W-9 Form:** ____ **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**
Mail: **20 North Martingale Road, Suite 180**
Schaumburg, IL 60173

Please assist us with having the most accurate and up-to-date information by completing this form and returning it to us promptly. You may also submit future changes to provider.contracting@fidelissc.com.