



The Essence of Care

Facility Information Form

Please contact Provider Relations for questions while completing this form.
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:

- Alamance Cabarrus Davidson Forsyth Guilford Mecklenburg Stanly

Services Provided:

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

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 |

Primary Location:

Directory Listing: Y or N

Name: _____ (dba): _____
 Address: _____ Office Contact: _____
 Phone: _____ Fax: _____ Tax ID: _____ NPI: _____
 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: _____
 Phone: _____ Fax: _____ Tax ID: _____ NPI: _____
 Medicare ID: _____ Medicaid ID: _____

Alternate Location:

Directory Listing: Y or N

Name: _____ (dba): _____
 Address: _____ Office Contact: _____
 Phone: _____ Fax: _____ Tax ID: _____ NPI: _____
 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.