HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

# Health Delivery Organization (HDO) and Vendor Application

**Important:** Incomplete applications will not be processed.

| | |
|---|---|
| Tax Identification Number (TIN): | |
| National Provider Identifier (NPI): | |
| Group Name: | |

| Credentialing Application Checklist | |
|---|---|
| Completed Application | |
| Copy of current accreditation (If not accredited, please include a copy of the most recent Centers for Medicare & Medicaid Services [CMS] – Medicare site survey.)<br>Accreditation organizations include:<br>• Accreditation Association for Ambulatory Health Care;<br>• American Academy of Sleep Medicine;<br>• American Association for Accreditation of Ambulatory Surgery Facilities;<br>• American Osteopathic Association;<br>• Commission for the Accreditation of Birth Centers;<br>• Commission on Accreditation of Rehabilitation Facilities;<br>• Community Health Accreditation Partner;<br>• Council on Accreditation;<br>• Det Norske Veritas;<br>• Office of Alcohol and Substance Abuse Services<br>• The Joint Commission Accreditation;<br>• RadSite; or<br>• Accreditation by other accrediting body. | |
| Copy of current state license/certificate license and applicable certificate(s). (For example, Commission on Office Laboratory Accreditation [COLA], Clinical Laboratory Improvement Amendments [CLIA]) | |
| Copy of W-9 (Include a W-9 for each location under a different name or Tax Identification Number.) | |
| Copy of current general and professional liability certificates. | |
| General and professional claims settlement history details<br>• Initial applicant: Provide any settlement or adjudication that resulted in payment of $25,000.00 or greater in the past five years.<br>• Recredentialing: Provide any settlement or adjudication that resulted in payment of $25,000.00 or greater in the past three years. | |
| Evidence of Medicare certification<br>• Include copy of the letter assigning the Medicare number if possible.<br>• If there are multiple locations, each location must have its own number or written permission to use an existing Medicare number. | |
| **(Facilities)** Copies of utilization management/quality assurance policies and procedures, as indicated, if not accredited. | |
| **(Facilities)** Copies of applicable policies and/or procedures, if requested in the application. | |
| **(Facilities)** Copy of current CMS' total performance score and performance adjustment report, if a home health provider in Arizona, Idaho, Nebraska, or Washington only. (Reports must be faxed to the Health Net Federal Services, LLC (HNFS) claims administrator at **1-844-730-1373**.) | |

Fax requested materials to **1-844-227-7689**.



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## Official Organization Name

Organization name listed with the Internal Revenue Service (IRS) (may be different from organization's doing business as [DBA] name):

## Business (Facility) Name (or DBA Name)

Provide legal used by the organization when conducting business (may differ from official organization name):

## Application Point of Contact

First/Last Name: Professional Title:

Phone: Fax:

Email:

## Facility/Vendor Location Address and Information

Use DBA address if different from the official organization address. Please fill out **Appendix D** if you have multiple locations. You also can complete the "Location-Facility (Optional)" tab in our **Network TRICARE Provider Roster template**.

Street Address: Suite/Number:

City: State: ZIP Code:

County:

Facility Main Line: Facility Fax (Required):

Billing Phone: Billing Fax: Emergency Phone:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

Recent change of address at this location? **Yes** **No**

If "Yes," provide previous facility address:

Street Address: Suite/Number:

City: State: ZIP Code:

Previous Address NPI: Previous Address TIN:

## Organization Type

Check all that apply.

Corporation (Inc.) Limited Liability Company (LLC) Nonprofit/Tax Exempt* Partnership Sole Proprietorship

Other List other type:

*If the organization is nonprofit/tax-exempt, include the IRS's *Exemption Determination Letter* with your application submission.

## Organization Website

Website Address:



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## Facility/Vendor Type

Select facility/vendor types that apply to your organization from the following facility/vendor type table.
Please indicate primary or secondary.

| Medical Service | Facility/Vendor Type | Primary | Secondary |
|---|---|---|---|
| Medical/Surgical Hospitals | Acute Care Hospital** | | |
| | Ambulatory Surgery Center (Freestanding)** | | |
| | Birthing Center | | |
| | Children's Hospital** | | |
| | End Stage Renal Dialysis Facility (ESRD) | | |
| | General Care Hospital** | | |
| | Long-Term Care Hospital** | | |
| | Hospice – Inpatient | | |
| | Materinity Hospital** | | |
| | Rehabilitation Hospital** | | |
| | Skilled Nursing Facility** | | |
| | Transplant Center*** | | |
| | Critical Access Hospital** | | |
| | Swing Beds (Only applies to Skilled Nursing Facilities and Critical Access Hospitals) | | |
| | Comprehensive Orthopedic Services | | |
| | Trauma Center<br>Primary: If "Yes," what is the trauma center level?<br>Secondary: If "Yes," what is the trauma center level? | | |
| | Emergency Services<br>If "Yes," is there a designated pediatric emergency department?<br>Primary: Yes No Secondary: Yes No | | |
| | Intensive Care Unit<br>Primary: If "Yes," what type of ICU is it?<br>Secondary: If "Yes," what type of ICU is it? | | |
| | Sole Community Hospital | | |
| | Other<br>Primary: If "Yes," list other here:<br>Secondary: If "Yes," list other here: | | |
| | **Behavioral Health Units within Acute Care Hospital:** | | |
| | Psychiatric Unit** | | |
| | Partial Hospitalization Program-Psychiatric** | | |
| | Partial Hospitalization Program-Chemical Dependency** | | |
| | Intensive Outpatient Program-Psychiatric** | | |
| | Intensive Outpatient Program-Chemical Dependency** | | |
| | Opioid Treatment Program (OTP)** | | |
| | Substance Use Disorder Rehabilitation Facility (SUDRF) Overnight Residential/Rehab** | | |

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## Facility/Vendor Type *(Continued)*

| Medical Service | Facility/Vendor Type | Primary | Secondary |
|---|---|---|---|
| **Behavioral Health** | Freestanding Psychiatric Hospital** | | |
| | Psychiatric Residential Treatment Center (PRTC)** | | |
| | Substance Use Disorder Rehab Facility (SUDRF) Overnight Residential/Rehab** | | |
| | Partial Hospitalization Program-Psychiatric | | |
| | Partial Hospitalization Program-Chemical Dependency | | |
| | Intensive Outpatient Program-Psychiatric | | |
| | Intensive Outpatient Program-Chemical Dependency | | |
| | Opioid Treatment Program | | |
| **Ancillary *(Include Outpatient Therapy Type)*** | Cardiac Rehabilitation | | |
| | Comprehensive Outpatient Rehabilitation Facility | | |
| | Freestanding Birth Center | | |
| | Home Health Agency | | |
| | Hospice – Community Based | | |
| | Pain Management Center | | |
| | Radiation Therapy Center | | |
| | Outpatient Therapy<br>Primary: If "Yes," list outpatient therapy type: ____________________<br>Secondary: If "Yes," list outpatient therapy type: ____________________ | | |
| **Corporate Services Provider** | AA – Radiation Therapy* | | |
| | AB – Cardiac Catheterization Clinic* | | |
| | AC – Freestanding Sleep Disorder Diagnostic Centers* | | |
| | AD – Independent Physiological Laboratories* | | |
| | AF – Freestanding Magnetic Resonance Imaging (MRI) Centers* | | |
| | AG – Comprehensive Outpatient Rehab Facility* | | |
| | AH – Home Health Agency – Children Only* | | |
| | AI – Freestanding Bone Marrow Transplant Center* | | |
| | AJ – Home Infusion Therapy* | | |
| **Vendor** | Ambulance Company | | |
| | Durable Medical Equipment Supplier | | |
| | Mammography Supplier | | |
| | Medical Product Supplier | | |
| | Outpatient Diagnostic Center | | |
| | Pharmacy-Specialty Drug Supplier | | |
| | Portable X-ray Service | | |
| | Prosthetic/Orthotic Supplier | | |
| | Radiology Diagnostic Center | | |

***Complete Appendix A** ****Complete Appendix B** *****Complete Appendix C**

**IMPORTANT:** If you have additional facilities covered by your TRICARE Preferred Provider Network Agreement, please fill out Appendix D if you have multiple locations. You also can complete the "Location-Facility (Optional)" tab in our **Network TRICARE Provider Roster template*.** * = https://www.tricare-west.com/content/hnfs/home/tw/prov/res/provider_forms/join_our_network/group-roster-template.html

**You must include a W-9 for each separate TIN with your application submission.**



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## Americans with Disabilities Act

Organization complies with the **2010 Standards for Public Accommodations and Commercial Facilities Title III**:

**Yes** **No** (If non-compliant, include explanation and/or correction action plan with application)

## Military Status

Does/do the owner/owners have an active military duty or active National Health Corps Service (Public Health) status?

**Yes** (If "Yes," review eligibility with your Provider Network Manager.) **No**

## Ownership and Administration (Non-Freestanding Corporations)

List the names, full addresses, and percentages of ownership for all organization owners.

| Owner Name (First and Last) | Address (Street, Unit/Number, City, State, ZIP Code) | Ownership Percentage |
|---|---|---|
| | | |
| | | |
| | | |

## Legal Standing

Has the organization or an officer, director, owner, or principal of the organization ever been convicted of or pled guilty to a felony or other violation of law concerning health care?

**Yes** (If "Yes," submit a statement of allegations and outcomes with your application) **No**

## Current Accreditations

Check all current accreditations that apply.

- Accreditation Association for Ambulatory Health Care
- American Academy of Sleep Medicine
- American Association for Accreditation of Ambulatory Surgery Facilities
- American Osteopathic Association
- Commission for the Accreditation of Birth Centers
- Commission on Accreditation of Rehabilitation Facilities
- Community Health Accreditation Partner
- Council on Accreditation
- Det Norske Veritas
- Office of Alcohol and Substance Abuse Services
- RadSite
- The Joint Commission Accreditation
- Other (List Other):

## Non-Accredited Organizations

List any non-accredited organizations:

### Skilled Nursing Facility Applicants:

For skilled nursing facilities not accredited by The Joint Commission, have you included a copy of the facility's most recent Life Safety Code & Health Care Facilities Code survey with your application? **Yes** **N/A**

### Other CMS-Surveyed Organizations:

For other organizations subject to CMS site surveys, have you included a copy of the most recent CMS/Medicare site survey with correction actions with your application? **Yes** **N/A**

## Operating Licenses

If you have multiple business locations, have you included each state and/or local operating license for each location with your application? **Yes** **N/A**

Are copies of state and/or local operating licenses included for each location listed in this application and covered in the TRICARE Preferred Provider Network Agreement? If there are no other locations or other operating licenses, select "N/A."

**Yes** **N/A**



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## Certifications Included (Attestation)

I attest that copies of the appropriate certifications (Commission on Office Laboratory Accreditation [COLA], Clinical Laboratory Improvement Amendments [CLIA], etc.) have been included. **Yes** **N/A**

If "Yes":

First and Last Name: Date of attestation (MM/DD/YYYY):

## CMS Standing

### Medicare Participation – Locations

If eligible, are all locations listed as "Medicare Participating" in your provider roster?

**Yes** **No** (If "No," review eligibility with your Provider Network Manager) **N/A** (Enter N/A if does not apply.)

### Medicare Participation – Status

Has your organization's Medicare participation ever been revoked, suspended or terminated?

**Yes** (If "Yes," submit a statement of allegations and outcomes with your application.) **No**

## Billing Agency

Company Name:

Street Address: Suite/Number:

City: State: ZIP Code:

County:

Phone: Fax:

POC First/Last Name: POC Professional Title:

## Primary Remittance Address

*(If different from "Billing Agency" section)*

Company Name:

Street Address: Suite/Number:

City: State: ZIP Code:

County:

Phone: Fax:

POC First/Last Name: POC Professional Title:

## Bankruptcy Status/Additional Information

In the past five years, has your organization filed a petition for relief under the U.S. Bankruptcy Code or has any action been taken in bankruptcy to dissolve, liquidate, terminate, consolidate, merge, or sell all or substantially all of your organization's assets or ownership interest(s)?

**Yes** (If "Yes," submit a statement of rationale and outcomes with your application) **No**



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## Management Contracts

Does your organization have management contract(s) with an outside organization or providing core services (administrative, staffing, personnel management, physician outsourcing [for example, ER, radiology, anesthesiology, pathology providers, etc.])?

**Yes** **No**

If "Yes," provide the following:

Company Name:

Services Provided:

## Risk Management

Refer to your TRICARE Preferred Provider Network Agreement for professional liability limit requirements and include a copy of the declaration page with your application.

Insurance Carrier Name:

Policy Effective Date (MM/DD/YYYY): Policy Expiration Date (MM/DD/YYYY):

Policy Liability Limits (Annual/Occurrence):

Declaration Page Included: **Yes** **No**

If "No," Provide Reason Not Included:

## General and/or Malpractice Liability Claims

Provide a confidential list of each general and professional malpractice liability claim(s) filed against your organization that resulted in a settlement or adjudication of $25,000 or greater **over the past five (5) years**. Excluding patient identifiers, provide claim type(s) and allegation(s), including diagnosis, treatment and disposition and amount awarded for each claim.

A detailed list of general or professional liability malpractice claims settled or adjudicated in the past five years has been included with application:

**Yes** **N/A** (Does not Apply)



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## Attestation

By signing my signature in the “Signature of Authorized Representative” section, I certify that:

- I have reviewed the information in this application and the attachments, and, to the best of my knowledge, our application submission is a complete and accurate representation of this organization’s operations.
- After reviewing our application, I understand that Health Net Federal Services, LLC (HNFS) may choose to do an on-site survey to verify TRICARE Program compliance and the accuracy of any information provided.
- If applicable, all licenses and certifications provided for the individuals listed in our provider roster are current and valid.
- Our organization’s accreditation and/or Medicare participation are current and valid.
- The enclosed/attested policies and procedures have been implemented and are enforced by this organization.
- Our organization maintains financial records that conform with generally accepted accounting principles and practices.
- I understand the effective date of participation, if granted, will be the first day of the month after the TRICARE Preferred Provider Network Agreement is actually executed and not the date the application was sent to or received by HNFS.
- I understand the organization is not eligible to submit claims for payment under the TRICARE Program until the organization has been approved by HNFS and has signed the TRICARE Preferred Provider Network Agreement.

## Release of Information

I acknowledge and agree that Health Net Federal Services, LLC (HNFS) has a valid interest and legal requirement to obtain and verify information concerning this organization’s professional competence; therefore, I consent to and authorize the release by any person or entity to HNFS, all information and documents that may be relevant to an evaluation of this organization’s professional competence, character, moral, and ethical qualifications, including any information or material relating to any disciplinary or criminal action, professional competence or suspension or curtailment of medical practices, including malpractice claims and/or coverage. I hereby release any such person or entity providing such information from any and all liability for doing so. If this organization has contracted with a medical group that has a participating TRICARE Preferred Provider Network Agreement with HNFS or such other health plans, they may also receive the credentialing information or quality assurance data relating to this organization. I understand that I have the burden and legal responsibility of providing adequate information to HNFS to demonstrate the organization’s professional competence, character, moral, ethics, and other qualifications. If any material changes occur affecting the professional status of this organization, I agree to notify HNFS within five (5) working days.

## Signature of Authorized Representative

Authorized Representative Printed Name (First/Last):

Authorized Representative Professional Title:

Authorized Representative Signature:

Date Signed by Authorized Representative (MM/DD/YYYY):

## Conditions for Coverage/Authorization

Your organization must meet all criteria to qualify as a Corporate Services Provider. Please confirm your organization meets all criteria by checking all that apply in this appendix.

| **Corporation or Foundation** *(Choose One)* | | |
|---|---|---|
| **Important:** Your organization must be a corporation or foundation but not a professional corporation or professional association. Check the box that applies to your organization. | | |
| **Corporation:** | Corporation (Not a Professional Corporation) | |
| | Partnership (Limited or General) | |
| | Limited Liability Corporation | |
| **Foundation:** | Nonprofit Charitable Organization under IRS Section 501(C)(3) | |
| **Affiliation** *(Choose One)* | | |
| **Institutional-Affiliated:** | | |
| **Freestanding:** | | |
| **Services/Supplies Type** *(Choose One)* | | |
| **Individual Professional Providers:** | Provide services and related supplies of a type rendered by individual professional providers employed directly or contractually by a corporation. | |
| **Technologists:** | Provide diagnostic technical services and related supplies of a type that requires direct patient contact and a technologist who is licensed by the state in which the procedure is rendered or who is certified by a qualified accreditation organization. | |
| **Level of Care** *(Check if Applicable)* | | |
| Provide the level of care that does not necessitate that the beneficiary be provided with on-site sleeping accommodations and food in conjunction with the delivery of the services, except for sleep disorder diagnostic centers in which on-site sleeping accommodations are an integral part of the diagnostic evaluation process. | | |
| **Payment** | | |
| Render services for which direct or indirect payment is expected to be made by Health Net Federal Services, LLC (HNFS) only after obtaining written authorization (that is, comply with applicable HNFS and/or plan[s] benefit authorization requirements before rendering designated services or items for which HNFS and/or plan cost-share/copayment may be expected). | | |
| **Responsibility** | | |
| Acknowledge and accept the responsibility for ensuring all individual practitioners meet the benefit plan reimbursements and comply with HNFS, federal, state, and local requirements and that these factors are accepted by the corporate entity itself. | | |

## Certification and Accreditation

| **Compliance with Licensing and Certifications** | |
|---|---|
| Comply with all extant state, county, municipality, or other jurisdiction licensing or certification requirements (organizational and individual) of the state, county, municipality, or other jurisdiction in which the corporate entity provides services. | |
| **Medicare Status** | |
| Maintain Medicare approval for payment when HNFS determines that a category or type of provider is substantially comparable to a provider or supplier for which Medicare has regulatory conditions of participation or conditions of coverage or, when Medicare-approved status is not required, be accredited by a qualified accreditation organization. | |



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# Appendix B: Hospitals, Ambulatory Surgery Centers, SUDRFS, Skilled Nursing Facilities

## General Organization Structure: Hospital

Please provide service metrics below.

| Service | Licensed Bed Total | Staffed Bed Total |
|---|---|---|
| Adult Medical/Surgical | | |
| Alcohol/Chemical Dependency | | |
| Cardiac Care Unit | | |
| Gynecology | | |
| In-Patient Hospice | | |
| Intensive Care Unit | | |
| Newborn | | |
| Obstetrics<br>*Average number of births per year:* | | |
| Other Intensive Care/Trauma | | |
| Labor Delivery Recovery Postpartum | | |
| Pediatrics | | |
| Physical Rehabilitation | | |
| Psychiatry | | |
| Skilled Nursing | | |
| Other | | |

## General Organization Structure: Skilled Nursing Facility

Please provide service metrics below.

| Service | Licensed Bed Total | Staffed Bed Total |
|---|---|---|
| Adult Medical/Surgical | | |
| Alcohol/Chemical Dependency | | |
| Cardiac Care Unit | | |
| In-Patient Hospice | | |
| Intensive Care Unit | | |
| Other Intensive Care/Trauma | | |
| Pediatrics | | |
| Physical Rehabilitation | | |
| Psychiatry | | |
| Skilled Nursing | | |
| Other | | |

# Appendix B (Continuing)

## Available Services: Ambulatory Surgery Center

Please provide details about your facility's services.

| Service | Available at facility? | |
|---|---|---|
| Ambulatory Surgery | **Yes** | **No** |
| Operating Rooms *If "Yes," number of operating rooms:* | **Yes** | **No** |
| Abortion Outpatient (Elective) | **Yes** | **No** |
| Computerized Tomography Scan (CT Scan) | **Yes** | **No** |
| Magnetic Resonance Imaging (MRI) | **Yes** | **No** |
| Other Special Care *If "Yes," specify type of special care:* | **Yes** | **No** |
| Outpatient | **Yes** | **No** |
| Obstetrics | **Yes** | **No** |

## Available Services: Hospital

Please provide details about your facility's services.

| Service | Available at facility? | |
|---|---|---|
| Occupational Therapy | **Yes** | **No** |
| Skilled Nursing, Long-Term | **Yes** | **No** |
| Speech Pathology | **Yes** | **No** |
| Angiography | **Yes** | **No** |
| Open Heart Surgery | **Yes** | **No** |
| Neurosugery | **Yes** | **No** |
| Ambulatory Surgery | **Yes** | **No** |
| Transplant *If "Yes," types:*<br>Heart, Heart/Lung, Kidney, Liver, Liver/Kidney, Lung, Multivisceral, Pancreas, Pediatric Heart/Lung, Pediatric Intestine/Liver/Multivisceral, Pediatric Liver, Small Intestine, Small Intestine/Liver | **Yes** | **No** |
| Operating Rooms *If "Yes," number of operating rooms:* | **Yes** | **No** |
| Trauma Unit *If "Yes," level of trauma:* | **Yes** | **No** |
| Cancer Treatment Center | **Yes** | **No** |
| Inpatient Psychiatric Unit | **Yes** | **No** |
| Other Special Care *If "Yes," specify type of special care:* | **Yes** | **No** |
| Outpatient Hemodialysis | **Yes** | **No** |
| Home Intravenous (IV) Series | **Yes** | **No** |
| Outpatient | **Yes** | **No** |
| Home Care Program | **Yes** | **No** |
| Partial Hospitalization | **Yes** | **No** |

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# Appendix B (Continuing)

## Available Services: Hospital

Please provide details about your facility's services.

| Service | Available at facility? | |
|---|---|---|
| Newborn Nursery | **Yes** | **No** |
| Pediatric Intensive Care Unit | **Yes** | **No** |
| Abortion Inpatient (Elective) | **Yes** | **No** |
| Abortion Outpatient (Elective) | **Yes** | **No** |
| Computerized Tomography Scan (CT Scan) | **Yes** | **No** |
| Magnetic Resonance Imaging (MRI) | **Yes** | **No** |
| Burn Care | **Yes** | **No** |
| Obstetrics | **Yes** | **No** |
| Organ Bank | **Yes** | **No** |
| Blood Bank | **Yes** | **No** |
| Urgent Care Clinic | **Yes** | **No** |
| Cardiac Rehabilitation | **Yes** | **No** |
| Substance Abuse Disorder Unit | **Yes** | **No** |

## Available Services: Skilled Nursing Facility

Please provide details about your facility's services.

| Service | Available at facility? | |
|---|---|---|
| Occupational Therapy | **Yes** | **No** |
| Skilled Nursing, Long-Term | **Yes** | **No** |
| Speech Pathology | **Yes** | **No** |
| Inpatient Rehabilitation | **Yes** | **No** |
| Other Special Care *If "Yes," specify type of special care:* | **Yes** | **No** |
| Cardiac Rehabilitation | **Yes** | **No** |

## Medical Staff Bylaws*

Bylaws and procedures attached *(check applicable)*

**Yes** **No** **N/A**

*If your organization is not accredited, you must include a copy of your medical staff bylaws and procedures.



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# Appendix C: Transplant Organizations

**Important:** Please include your "Transplant Acquisition Cost Letter/Worksheet" with your application.

## Transplant Types Performed

Please check all that apply.

| Transplant Type | Available at facility? | |
|---|---|---|
| Heart | **Yes** | **No** |
| Heart/Lung | **Yes** | **No** |
| Kidney | **Yes** | **No** |
| Liver | **Yes** | **No** |
| Liver/Kidney | **Yes** | **No** |
| Lung | **Yes** | **No** |
| Multivisceral | **Yes** | **No** |
| Pancreas | **Yes** | **No** |
| Pediatric Heart/Lung | **Yes** | **No** |
| Pediatric Intestine/Liver/Multivisceral | **Yes** | **No** |
| Pediatric Liver | **Yes** | **No** |
| Small Intestine | **Yes** | **No** |
| Small Intestine/Liver | **Yes** | **No** |

## Transplant Volume

How many transplants performed in one year?

## Transplant Program/Network

Please provide the participating donor organ procurement program and network.

Procurement Program:

Network:

## Organization Operations

| Operations Function | Available at facility? | |
|---|---|---|
| Interdisciplinary body for equitably determining candidate suitability for transplantation. | **Yes** | **No** |
| Anesthesia team available at all times. | **Yes** | **No** |
| Nursing service trained in hemodynamic patient support/managing immunosuppressed patients. | **Yes** | **No** |
| Pathology and immunology resources available for studying and reporting pathological reasons for transplantation. | **Yes** | **No** |
| Policies and procedures safeguarding patient rights and privacy. | **Yes** | **No** |
| Compliance with state transplantation laws/regulations, if any. (Include any noncompliance issues as a separate attachment.) | **Yes** | **No** |
| Legal counsel familiar with transplantation laws/regulations. | **Yes** | **No** |



**Internal Use Only:** **Contract Document Control Number:** ____________ **Approved** (MM/DD/YYYY):__________ **TIN:** ______________

# Appendix D: Additional Facility/ Vendor Locations

**IMPORTANT:** If you have additional facilities covered by your TRICARE Preferred Provider Network Agreement, please fill out this appendix if you have multiple locations. You also can complete the "Location-Facility (Optional)" tab in our **Network TRICARE Provider Roster template**.

**You must include a W-9 for each separate TIN with your application submission.**

Use facility/vendor type categories listed in the Facility/Vendor Type section table.

1. Facility Name:

Street Address: Suite/Number:

City: State: ZIP Code: County:

Facility POC Name: Facility POC Email:

Facility POC Phone: Facility Fax (Required):

Emergency Phone: Facility/Vendor Type:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*

Street Address: Suite/Number:

City: State: ZIP Code:

2. Facility Name:

Street Address: Suite/Number:

City: State: ZIP Code: County:

Facility POC Name: Facility POC Email:

Facility POC Phone: Facility Fax (Required):

Emergency Phone: Facility/Vendor Type:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*

Street Address: Suite/Number:

City: State: ZIP Code:

*Continues on next page*



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# *Appendix D: Additional Facility/Vendor Locations (Continued)*

**3**. Facility Name:
Street Address: Suite/Number:
City: State: ZIP Code: County:
Facility POC Name: Facility POC Email:
Facility POC Phone: Facility Fax (Required):
Emergency Phone: Facility/Vendor Type:
NPI Type II: Medicare Number:
Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*
Street Address: Suite/Number:
City: State: ZIP Code:

**4**. Facility Name:
Street Address: Suite/Number:
City: State: ZIP Code: County:
Facility POC Name: Facility POC Email:
Facility POC Phone: Facility Fax (Required):
Emergency Phone: Facility/Vendor Type:
NPI Type II: Medicare Number:
Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*
Street Address: Suite/Number:
City: State: ZIP Code:

**5**. Facility Name:
Street Address: Suite/Number:
City: State: ZIP Code: County:
Facility POC Name: Facility POC Email:
Facility POC Phone: Facility Fax (Required):
Emergency Phone: Facility/Vendor Type:
NPI Type II: Medicare Number:
Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*
Street Address: Suite/Number:
City: State: ZIP Code:

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# *Appendix D: Additional Facility/Vendor Locations (Continued)*

**6**. Facility Name:

Street Address: Suite/Number:

City: State: ZIP Code: County:

Facility POC Name: Facility POC Email:

Facility POC Phone: Facility Fax (Required):

Emergency Phone: Facility/Vendor Type:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*

Street Address: Suite/Number:

City: State: ZIP Code:

**7**. Facility Name:

Street Address: Suite/Number:

City: State: ZIP Code: County:

Facility POC Name: Facility POC Email:

Facility POC Phone: Facility Fax (Required):

Emergency Phone: Facility/Vendor Type:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*

Street Address: Suite/Number:

City: State: ZIP Code:

**8**. Facility Name:

Street Address: Suite/Number:

City: State: ZIP Code: County:

Facility POC Name: Facility POC Email:

Facility POC Phone: Facility Fax (Required):

Emergency Phone: Facility/Vendor Type:

NPI Type II: Medicare Number:

Taxonomy Code: TIN:

**Billing Address** *(If differs from main location)*

Street Address: Suite/Number:

City: State: ZIP Code:



**Internal Use Only: Contract Document Control Number:** ____________ **Approved** (MM/DD/YYYY):__________ **TIN:** ________________