

Nursing Facility Demographic Information Form

Please complete one form per facility. Complete all fields to avoid a delay in processing.

New facility
 Change of ownership
 Other update(s): _____

Facility name (DBA):		Tax ID:	
Legal/tax name:		NPI:	
Taxonomy code(s):		Provider type: <input type="checkbox"/> NH <input type="checkbox"/> SNF	
Physical location information			
Address:			
City:	State:	ZIP code + 4:	
Phone #:	Fax #:		
Billing/payment remittance address			
<input type="checkbox"/> Same as physical address. If different, complete section below.			
Address:			
City:	State:	ZIP code + 4:	
Phone #:	Fax #:		
Facility contacts			
Administrator name:			
Email:		Phone:	
Parent company name (if applicable):			
Primary contact name:			
Email:		Phone:	
Business office manager/billing contact:			
Email:		Phone:	
Credentialing contact:			
Email:		Phone:	
Contracting contact:			
Email:		Phone:	
License information			
Medicare/OSCAR PTAN:			
Is the facility ADA handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signature			
Printed name:			
Signature:		Date:	

<https://provider.amerigroup.com>

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