HCAP USE:
DB _____
INITIALS _____

HCAP ANCILLARY – PROVIDER GROUP INFORMATION

EFFECTIVE DATE: _____

GENERAL INFORMATION

PLEASE SUBMIT CURRENT W-9

Provider Name	National Provider ID Number
Federal Tax ID Number	License Number

LOCATION(s) – PLEASE LIST ADDRESSES AS YOU WISH THEM TO APPEAR IN DIRECTORY

Primary Site Address: Name *if different from Provider Name above* **I**

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	
Federal Tax ID Number (if different than above)		National Provider ID Number *(if different from above)*	

Secondary Site Address: Name *if different from Provider Name above* **I**

Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	
Federal Tax ID Number (if different than above)		National Provider ID Number *(if different from above)*	

Attach a separate sheet for other locations.

Billing Remittance Address: (if different than above)

Name			
Street		Suite No., P.O. Box No.	
City	State	Zip	County
Telephone ( )		Fax ( )	

SERVICE SCOPE

Please place an "x" in the appropriate box to designate under which service you wish to be listed in the *HCAP Directory of Network Providers.* More than one box can be checked.

- ❑Acute Care
- ❑Ambulatory Care
- ❑Ambulatory Surgery
- ❑Business Health
- ❑Cancer Treatment Center
- ❑Diagnostic Breast Imaging
- ❑Diagnostic Radiology
- ❑Dialysis Services
- ❑Durable Medical Equipment
- ❑Electrotherapy – Products & Service
- ❑Family Practice
- ❑Hemodialysis
- ❑Home Health Care
- ❑Hospice
- ❑Hospice Residential Facility
- ❑Immunizations Only
- ❑Infusion Therapy
- ❑Laboratory/Pathology
- ❑Long Term Acute Care Hospital
- ❑Long Term Care
- ❑Mental Health IP
- ❑Mental Health OP
- ❑Nuclear Medicine
- ❑Occupational Therapy
- ❑Orthotics
- ❑Pediatric Rehabilitation – SP.OT, PT
- ❑Physical Therapy
- ❑Private Duty Nursing
- ❑Prosthetics
- ❑Prosthetics and Orthotics
- ❑Psychological Center
- ❑Rehabilitation IP
- ❑Rehabilitation OP
- ❑Respiratory Therapy
- ❑Skilled Nursing Care
- ❑Sleep Disorders
- ❑Speech Therapy
- ❑Substance Abuse IP
- ❑Substance Abuse OP
- ❑Urgent Care
- ❑Rehabilitation IP
- ❑Women's Health Care
- ❑Other _____
- ❑Other _____

Are you accepting new patients: Yes _____ No_____

HOSPITAL AFFILIATION(s)

Please list hospital(s) which you may have an affiliation. Attach a separate sheet if necessary.

1. _____
2. _____
3. _____

OFFICE CONTACT PERSON

The person identified below may be contacted for additional information regarding the above information or other information as needed.

Name _____ Title _____

Telephone (___)_____ E-Mail Address _____

PROVIDER CERTIFICATION

I certify that the information contained herein is true and correct to the best of my knowledge. I understand that misrepresentation may result in non-selection, or, if discovered after selection, in termination as an HCAP provider. I understand that this application does not entitle participation in the HCAP network. I authorize HCAP to consult with and inspect all documents from individuals and organizations having information bearing on qualifications, and authorize the copy of my signature on the application to be as binding as the original. I agree that HCAP, its representatives, and any individuals or entities providing information to HCAP in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this application. I further agree to notify HCAP in a timely manner of any change to the information requested in this application. HCAP will treat all information requested in this application that is not publicly available as confidential.

_____
Print Name

_____ _____ _____
Signature Title Date

RETURN APPLICATION TO:

Health Care Alliance Pool
315 Mulholland Street
Bay City, MI 48708
Telephone: (989) 891-8820 Fax: (989) 891-8161