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__Document:	Agency Information Form
Description:	General Provider agency information required for contracting and ongoing outreach.
Directions:	Please complete the information listed below and **submit a W9** for each Tax ID.

Agency Information Form	
1. Agency Type (Please Select All Applicable): ☐ Home Health Agency ☐ Durable/Home Medical Equipment ☐ Specialty Pharmacy for Infusion Therapy ☐ Other	
2. Reason for Request (Please Select All Applicable): ☐ New Network Provider Agreement ☐ Add to Existing Network Agreement ☐ Other	
3. Legal Agency Name:	
4. Doing Business As (DBA) Name:	
5. Ownership Entity or Group Name (If Applicable):	
6. **Multiple Facilities:** _____ NO _____ / _____ YES / Number of Branches ➢ If YES, Please complete Attachment A for each branch. ➢ If Yes, Do You Have Centralized Contracting? ___ NO ___ YES (If Yes, provide contact information in space below)	
7. Primary Contact Name: **Title:** **Email Address:**	**Authorized Provider Official? ___ NO ___ YES** **Phone Number:**
8. Credentialing Contact Name: **Title:** **Email Address:**	 **Phone Number:**
9. Agency Primary Address: **City:** **State:**	 **Zip Code:**
10. Agency General Contact Information: **Website:** **Telephone:**	**Email:** **Fax:**
11. Federal Tax I.D. #:	**12. National Provider Identifier #:**
13. State License #:	**Expiration Date:**
14. CMS Certification # (If Certified):	**15. Medicaid # (If Certified):**
16. Census – Average Daily:	**17. Census – Full Capacity:**

FOR QUESTIONS OR TO SUBMIT FORM, PLEASE RETURN TO ATTN: PROVIDER NETWORK:
➢ **VIA FAX AT 615-988-9947** **OR** ➢ **VIA EMAIL AT CONTRACTING@MYNEXUSCARE.COM**

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18. **Have you had any Medicare/Medicaid sanctions within the past 10 years?** _____ NO _____ YES ➢ If YES, Are these Sanctions still active? _____ NO _____ YES _________ Sanction Expiration Date	
19. Is your Agency Accredited? If so, by whom and when does the accreditation expire?	

ATTACHMENT A

If More Than Three Locations, Please Copy or Send Requested Information in a Directory Format

Please complete the information listed below and **submit a W9** for each Tax ID.

Location 1

Branch Name: **Primary Address:** **City:** **State:** **Zip Code:**	
General Contact Information: **Email:** **Telephone:** **Fax:**	
Federal Tax I.D. #:	**National Provider Identifier #:**
State License #:	**State License Expiration Date:**
CMS Certification # (If Certified):	**Medicaid # (If Certified):**
Census – Average Daily:	**Census – Full Capacity:**
Primary Contact Name and Title (If Different than Previously Listed Contact): **Email Address:** **Phone Number:**	

Location 2

Branch Name: **Primary Address:** **City:** **State:** **Zip Code:**	
General Contact Information: **Email:** **Telephone:** **Fax:**	
Federal Tax I.D. #:	**National Provider Identifier #:**
State License #:	**State License Expiration Date:**
CMS Certification # (If Certified):	**Medicaid # (If Certified):**
Census – Average Daily:	**Census – Full Capacity:**
Primary Contact Name and Title (If Different than Previously Listed Contact): **Email Address:** **Phone Number:**	

Location 3

Branch Name: **Primary Address:** **City:** **State:** **Zip Code:**	
General Contact Information: **Email:** **Telephone:** **Fax:**	
Federal Tax I.D. #:	**National Provider Identifier #:**
State License #:	**State License Expiration Date:**
CMS Certification # (If Certified):	**Medicaid # (If Certified):**

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Census – Average Daily:	Census – Full Capacity:
Primary Contact Name and Title (If Different than Previously Listed Contact): Email Address:	 Phone Number:

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