__Document:	Agency Information Form
Description:	General Provider agency information required for contracting and ongoing outreach.
Directions:	Please indicate information and return upon completion.

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:** **Authorized Provider Official?** ☐ **NO** ☐ **YES**

Title:

Email Address: **Phone Number:**

8. **Agency Primary Address:**

City: **State:** **Zip Code:**

9. **Agency General Contact Information:** **Website:** **Email:**

Telephone: **Fax:**

10. **Federal Tax I.D. #:**

11. **National Provider Identifier #:**

12. **State License #:** **Expiration Date:**

13. **CMS Certification # (If Certified):**

14. **Medicaid # (If Certified):**

15. **Census – Average Daily:**

16. **Census – Full Capacity:**

17. **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

18. **Is your Agency Accredited? If so, by whom and when does the accreditation expire?**

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**

ATTACHMENT A

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

Location 1	**Branch Name:** **Primary Address:** **City:** **State:** **Zip Code:**	
	General Contact Information: **Email:** **Telephone:** **Fax:**	
	Federal Tax I.D. #:	**NPI #:**
	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. #:	**NPI #:**
	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. #:	**NPI #:**
	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:**	

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