

<b>HCAP USE:</b> DB _____ INITIALS _____
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## 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 |

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

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

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

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

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