Facility Notification Form Help 2021

New Location

Effective Date: Effective / opening date of facility
List in Provider Directory: Should the facility be listed in electronic and paper directories? Yes or No
Location Name: The complete legal name of institution, corporate entity, practice, or individual provider
Physical Address: The number and street name associated with the new location
City: City associated with physical address
State: State associated with physical address
Zip: Zip code associated with physical address
County: County in which the new facility is located
Accepts mail at this address. Is mail delivered by the USPS at this address? Select Yes or No
Clinic Phone Number: Business telephone number to be published in electronic and paper directories
Clinic Fax Number: Business fax number for referrals or prior authorizations
Clinic Manager Name: Complete name of the clinic manager
Clinic Manager Phone: Business telephone number associated with the clinic manager
Business Fax: Business fax number associated with the clinic manager
Clinic Manager Email: Business email associated with the clinic manager
Billing Tax ID: The nine-digit identification number used by the Internal Revenue Service in the administration of tax laws for this location
Billing Contact Name: Complete name of the individual responsible for billing within the organization or corporate entity
Billing Name (Check Payable To): Complete legal name of the organization or corporate entity
Billing Address: Billing address where payments should be mailed
Billing City: City associated with billing address
Billing State: State associated with billing address
Billing Zip: Zip associated with billing address
Billing Phone: Telephone number associated with billing organization or contact
Billing Fax: Fax associated with billing organization or contact
Billing Email: Email associated with billing organization or contact
Rural Health Clinic: Indicate if the location is a Rural Health Clinic
Swing Bed: Applies to hospitals and Skilled Nursing Facilities - Indicate if the hospital has a Swing Bed
Beds: Applies to hospitals and Skilled Nursing Facilities – Indicate the number of beds
Essential Community Providers – Select any Essential Community Provider types applicable to the location
On Call/After Hours: Indicate if the facility offers extended hours
Regular Hours: Indicate the office hours available at this location
Facility NPI 2: Physical National Provider Identification number associated with the location
Facility Type: Indicate the type of facility (ie Clinic, hospital)
Taxonomy Code: Code description that most closely describes the facility type / classification / specialization for purpose of rendering health care. If applicable, enter more than one code description to adequately describe the type / classification / specialization
Billing NPI: The unique 10-digit identification NPI number for covered health care providers
Practitioners at this Location: Provide a list of all existing practitioners that will be seeing patients at the new location. Note: For new practitioners, please complete the Practitioner Form as well.

Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address associated with contact
Phone: Telephone number associated with contact

Update Location

Facility Name: The facility name of the location that requires an update
Facility NPI: The unique 10-digit identification number for covered health care facility
Effective Date: Date of Change or Update
Reason for Change: Indicate the reason or type of change
Change Request: Provide details related to what you would like changed
Location Name: The practice name of the location
Physical Address: The number and street name associated with organization
City: City associated with physical address
State: State associated with physical address
Zip: Zip Code associated with physical address
County: County in which the location is located
Clinic Phone: Telephone number associated with location
Clinic Fax: Fax Number for submission of referrals or authorization documentation for location
Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address associated with contact
Phone: Telephone number associated with contact

Terminate Location

Termination Date: Complete the date of termination if the location is terming
Terminating Facility Name: The facility name of the location that is terming
Physical Address: The number and street name associated with organization
City: City associated with physical address
State: State associated with physical address
Zip: Zip Code associated with physical address
County: County in which the location is located
Phone: Telephone number associated with location
Billing NPI: The unique 10-digit identification NPI number for covered health care providers
Reason for Terming: Using the drop-down menu, select the reason for termination
What Practitioners are Relocating: Enter the name of each practitioner and the location where the practitioner will be relocating because of the location termination
Practitioners at this Location: Provide a list of all practitioners that will be terming from the termed location
Completed by: Name of the individual completing this form. Individual must be authorized to represent the provider office for enrollment with health insurance payers
Email Address: Email address associated with contact
Phone: Telephone number associated with contact