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Out of Network Service Notification

Please note: A W9 is REQUIRED with submission of your Out of Network Service Notification Form. For multiple upload an agency roster or reload this form.

Health Plan: _____

Agency Information

Agency Name (as filed with IRS)		TIN	
DBA Name (if applicable)		NPI	
Branch Address			
City		State	Zip
Billing Address			
City		State	Zip

Contact Information

Contact Name	Contact Title	Contact Phone Number
Contact Email		

Branch Information

Branch Phone Number	Branch Fax Number	Authorization Phone Number	Authorization Fax Number
Number of in State Branches	List of Servicing Counties		

Scope of Services

Skilled Nursing
 Physical Therapy

Occupational Therapy
 Speech Therapy

Home Health Aide (must be paired with SN, PT, OT or ST)
Medical Social Worker

I attest that the information provided within this form is true and accurate

Please sign here: