

Health Care Payers Coalition of New Jersey

Ancillary Facility Credentialing Profile

Office Information: (A profile must be completed for each location)

Provider Name _____

Address _____

Phone _____ Fax _____

Principal Contact Person
(Name) _____

(Title) _____

Services Provided/Specialty

Licensing/Accreditation

Federal Tax Identification # _____

State License _____

Licensure Category _____

Medicare Provider Part A _____

Medicare Provider Part B _____

Medicaid Provider Number _____

Accreditation _____

Certification (Specialty) _____

Ownership

Non-Profit

Privately Held

For Profit

Publicly Held

Date of Incorporation _____

Part of Another Organization/System

If yes, please name _____

Insurance Information

Company _____

Address _____

Policy # _____

Hours of Operation

Weekdays _____

Weekend _____

Holidays _____

On-Call/After Hours Arrangements

On-Call Hours _____

Answering Service _____

Voice Mail _____

In-House Clinician _____

Geographic Service Area

State(s) _____

County(s) _____

Referral/Intake Department:

Hours of Operation _____

Contact Person _____

Phone _____ Fax _____

Billing Department

Hours of Operation _____

Contact Person _____

Street Address _____

City/State _____ Zip Code _____

Phone _____ Fax _____

Please include the following documentation with this form:

- Curriculum Vitae (if applicable)
- Copy of license
- Copy of most recent Accreditation
- Copy of Liability Insurance
- Copy of Certification
- Tax Coupon, W-9 or other form of documentation to support TIN
- Copy of Medicare Provider Number (if applicable)
- Copy of Medicaid Provider Number (if applicable)
- Brochure

Provider Signature Date

Print Name Title