Hospital Demographic Form

REQUIRED DOCUMENTS

Below is a check list of documents you will need to complete and provide:

- ☐ Signed and dated W-9 with IRS registered legal business name and billing address information. Use only one TIN. This legal name must match the name on the Participating Provider Agreement.
- ☐ Signed Participating Provider Agreement. Do not populate effective dates.

Return by mail to:

Superior HealthPlan
Network Development/Hospital Contracting
7990 Interstate 10 West, Suite 300
San Antonio, TX 78230

DEMOGRAPHIC INFORMATION

Legal Business Name: _____

Facility Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Facility Phone: _____ Facility Fax: _____

Tax ID: ___-_____ NPI: _____ Medicare Certification Number: _____ Facility TPI: _____

Specialty: _____ Sub-specialty: _____

Primary Taxonomy: _____ Additional Taxonomy: _____

DEMOGRAPHIC INFORMATION

Please list additional inpatient hospital facility locations operating under the same Tax ID, NPI, Medicare ID and TPI referenced above to ensure information is updated for Superior Provider Directories. Please attach an additional list if needed.

Facility Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County: _____

Facility Phone: _____ Facility Fax: _____

Are there additional NPI's used for claim submission purposes covered under the same facility licensure?
☐ Yes ☐ No
If Yes, complete information below.

Additional Facility NPI's: _____

Additional Specialties: _____

Is this location handicap accessible? ☐ Yes ☐ No

Please note: When attaching your signed and dated W-9, please make sure you list your primary billing address.

MINORITY OWNED BUSINESS

Are you designated as a Minority Owned Business? ☐ Yes ☐ No

BUSINESS DISCLOSURE

Have **You** or any **Affiliate** ever held (prior to now) a provider contract or done other **Business** with Superior HealthPlan or any of its affiliates?

☐ Yes ☐ No

As used above, the capitalized terms are defined as follows:

You - The individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan.

Affiliate - An entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to you or to Superior.

Business - Holding a contract for provider services, vendor services or other services with Superior or an affiliate of Superior.

If **You** answered Yes above, please provide the following information. Please attach additional list if needed.

Legal name of the entity with a prior contract or other business:

_____

_____

_____

Business address of such entity:

_____

_____

_____

Federal tax ID number of such entity: _____

Entity's relationship to you:

_____

_____

_____

Signed: _____ Name: _____

Title: _____ Date: _____

APPLICATION ATTESTATION

Please answer every question below in this section. Every question must be answered. For any question(s) answered Yes, please provide a detailed explanation on a separate document and attach.

1. Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of a health-care item or service?

   ☐ Yes ☐ No

2. Has this facility, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked, suspended or been issued a conditional license? This includes the surrender of such license while a formal disciplinary proceeding was pending before a state licensing authority.

   ☐ Yes ☐ No

3. Has this facility, under any current or former name or business identity, ever had accreditation revoked or suspended?

   ☐ Yes ☐ No

4. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by a federal or state health-care program, or any disbarment from participation in any federal executive branch procurement or non-procurement program?

   ☐ Yes ☐ No

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire application are true, accurate and complete to the best of my knowledge.

I fully understand that any falsification of participating providers is cause for summary dismissal from Superior HealthPlan. I understand that acceptance of this application does not constitute approval or acceptance of participating status with Superior and grants no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is obtained from Superior.

Printed Name of Authorized Representative _____ Authorized Representative's Title _____

Signature of Authorized Representative _____ Date Signed _____

CREDENTIALING CONTACT INFORMATION

Contact Name: _____ Contact Title: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____