NURSING FACILITY DEMOGRAPHIC FORM

FACILITY CONTACT INFORMATION - ONE PER FACILITY REQUIRED

Facility Name: _____ Tax ID Number: _____

Phone: _____ Fax: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Billing/ Payment Remittance Address: _____

City: _____ State: _____ Zip: _____

Parent Company Name: _____

Parent Company Address: _____

City: _____ State: _____ Zip: _____

LICENSE INFORMATION

Tax Identification Number (TIN): Please attach current W-9 form: _____

National Provider Identifier (NPI): _____ Taxonomy: _____

Does your facility desire to have SNF Beds under contract? ☐ Yes ☐ No

Please Note: Skilled Nursing Facility Services require a separate contract, must complete credentialing and have current general and professional liability insurance at acceptable levels.

Signature: _____ Date: _____

CHANGES TO THIS INFORMATION

The provider may amend the demographic information included herein, and add or remove facilities from the scope of the Agreement, by providing Superior at least 30 days advance written notice of such changes.