3905 Dakota St • Alexandria, MN 56308
1-888-588-4420 • Fax 1-320-335-5336
www.primewest.org

LEAVE NOTHING BLANK
Please print or type all information. If the question does not apply, enter N/A. ***Incomplete forms will be returned.***

NETWORK INFORMATION REQUEST – CONTRACTED FACILITY

1. Name of person completing this form: ______________________________

2. Telephone: ____________________ 3. Email address: ____________________

4. Facility type (check one): ☐ Clinic ☐ Hospital ☐ Surgical Center ☐ NH/LTC ☐ Wellness Provider
☐ Other: ____________________

A. DEMOGRAPHIC INFORMATION

1. Legal name: ______________________________
IMPORTANT: *This should be the business name you use to file income to the IRS. (This is also the first line of the* ***W-9 Form****.)*

2. DBA name: ______________________________
This should be the name you are doing business as. (This is also the second line of the ***W-9 Form****.)*

3. Federal tax ID #: ______________________________

4. Are you associated with a parent company? ☐ Yes ☐ No If yes, please indicate: ____________________

5. Physical address: ______________________________

6. City, state, zip: ____________________ 7. County: ____________________

8. Telephone: ____________________ 9. Fax: ____________________
This is the number that will be listed in the ***Provider Directory****.*

10. Email address: ______________________________

11. Website address: ______________________________

12. Mailing address: ______________________________
Street Address or P.O. Box *City* *State* *Zip*

13. Organizational structure (check one):
**Critical Access Hospitals must include a copy of their CMS Critical Access Hospital acceptance letter and rates for all services.*

☐ Community Health Clinic
☐ Community Mental Health Center
☐ Critical Access Hospital*
☐ Federally Qualified Health Center
☐ Minnesota Rural Health Cooperative
☐ Rural Health Clinic
☐ State Operated Services
☐ Other *(describe)*: ____________________
☐ N/A

B. CONTACT INFORMATION

Provide the following information for contact people at your facility.

TITLE	NAME	TELEPHONE	EMAIL ADDRESS
a. Administrator/ Facility Site Manager			
b. Business/Billing Office Manager			
c. Director of Nursing/ Nursing Supervisor			
d. Medical Director/ Chief of Staff			
e. Credentialing			

C. BILLING INFORMATION

Be sure your billing name and address are listed correctly below. This is the name and address to which remittances and correspondence will be sent. This should be the name and address that appear in Box 33 of the ***CMS 1500 form*** and Field 1 of the ***UB92 form***. **(If the information on your claim differs from the information you provide here, the claim may be delayed or denied.)**

1. Billing name: ______________________________

Billing address: ______________________________
Street Address or P.O. Box

____
City *State* *Zip*

2. Are you currently enrolled as a Medicaid provider with the State of Minnesota? ☐ Yes ☐ No

3. Are you currently enrolled as a Medicare provider with the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No

3a. If "yes," provide your Medicare number______________________________

4. NPI #*:______________________________

5. UMPI #*: ______________________________

***If you have more than one NPI/UMPI number, please use the form on page 9. Please label what each NPI/UMPI number is for (e.g., clinic, swing bed, pharmacy, etc.).**

D. INSURANCE INFORMATION – *Mandatory*

a. Attach a copy of your certificate of liability and coverage limits from your general liability policy.

b. Attach a current copy of the professional liability certificate for each practitioner providing billable services through your facility.

E. SERVICES AVAILABLE

1. Check any service that is provided at this facility. If the service is provided at the facility but billed by another entity, provide the name of the billing entity. If the service is not listed, please check "Other" and list.

- ☐ Acupuncture (by MD or supervised by MD)
- ☐ Ambulatory Surgery
  - ☐ Freestanding Surgery Center
- ☐ Audiology
- ☐ Behavioral Health
  - ☐ CTSS Certified*
- ☐ Case Management
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Child Care
- ☐ Chiropractor
- ☐ Dental
- ☐ Dialysis
- ☐ Diabetes Education
- ☐ Dietician/Nutrition
- ☐ DME (please complete attached checklist on pages 10-11)
- ☐ Eyewear
- ☐ Fitness Professional
  - ☐ Exercise Specialist
- ☐ Hearing Aid Center
- ☐ Home and Community Based Services (HCBS)
- ☐ Home Health Care
  - ☐ Medicare Certified*
- ☐ Hospice
- ☐ Language Interpreter (on-site)
  Language(s) ______________ ________________________
- ☐ Mammography
- ☐ Midwifery
- ☐ Nuclear Medicine
- ☐ Mobile Lithotripsy
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Orthotics
- ☐ PCA
- ☐ Pharmacy
  - ☐ MTMS Certified**
- ☐ Physical Therapy
- ☐ Podiatry
- ☐ Prosthetics
- ☐ Radiology
- ☐ Radiation Therapy
- ☐ Skilled Nursing Facility
- ☐ Speech Therapy
- ☐ Swing Beds
- ☐ Telemedicine
- ☐ Telephonic Interpretation
- ☐ Transportation
  - ☐ Ambulance Service
  - ☐ Common Carrier Transportation
  - ☐ Special Transportation Services
- ☐ Wellness Provider
- ☐ Other *(list below)*:
  a. ____________________________
  b. ____________________________
  c. ____________________________

***You must provide a copy of the facility's current certificate.**

****You must provide a copy of the current Medication Therapy Management Services (MTMS) certification of the practitioner.**

2. Is your facility a medical clinic? ☐ Yes ☐ No
   If yes, which do you provide? ☐ OB/GYN ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

3. Does your facility have an age restriction in administering care to members or members? ☐ Yes ☐ No
   If yes, what is the age restriction? (For example, 18 and under only.)

4. Do you provide "in-house" laboratory services? ☐ Yes ☐ No
   If yes, is the lab CLIA certified? **(If CLIA certified, you must provide a copy of the most current CLIA certificate.)**

5. **Do you employ any practitioners who will bill for their professional services through this entity?** ☐ Yes ☐ No
   If yes, submit a ***Minnesota Universal Credentialing Application*** or an ***Exercise Specialist Credentialing Application*** for each practitioner and provide a current practitioner list with title and specialty, NPI/UMPI number, and his/her employment status (employed or non-employed [e.g., outreach]). Credentialing applications can be found on the PrimeWest Health website in the *Partners & Providers* section under *Helpful Links*.

F. EMERGENCY ROOM / URGENT CARE – Hospitals Only

Provide details of how members access care at your hospital.

1. Is the ER open 24 hours/day and 7 days/week?
   ☐ Yes
   ☐ No
   If no, indicate when it is not open:

2. Does the hospital provide Urgent Care hours (separate from the ER)?
   ☐ Yes
   ☐ No
   If yes, please complete the grid at right:

3. URGENT CARE HOURS	FROM—TO
Monday	–
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

G. CALL COVERAGE AND OFFICE HOURS – Facilities Only

1. Please indicate how members of your facility are instructed to access care when the primary clinic is not open. Check as many as apply.

- ☐ Answering machine directs members how to access care – no "live" person answering
- ☐ Answering service directs members how to access care – "live" person answering, but no medical advice given
- ☐ Answering service directs members how to access care and has nurses available to answer medical questions
- ☐ Members seen after hours when necessary by on-call clinic physician at clinic or hospital
- ☐ Members referred to hospital emergency room (ER) and seen by ER physician
- ☐ Other *(describe):* ______________________________

2. Does your facility provide extended care hours? ☐ Yes ☐ No
If yes, please fill out hours in section 4 in the grid below.

3. REGULAR OFFICE HOURS	FROM—TO	
Monday	–	☐ Closed
Tuesday	–	☐ Closed
Wednesday	–	☐ Closed
Thursday	–	☐ Closed
Friday	–	☐ Closed
Saturday	–	☐ Closed
Sunday	–	☐ Closed

4. EXTENDED CARE HOURS	FROM—TO
Monday	–
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

5. HOLIDAY HOURS	FROM—TO	
New Year's Day	–	☐ Closed
Martin Luther King Day	–	☐ Closed
President's Day	–	☐ Closed
Memorial Day	–	☐ Closed
July 4th	–	☐ Closed
Labor Day	–	☐ Closed
Thanksgiving	–	☐ Closed
Christmas Day	–	☐ Closed
Other: ______________	–	☐ Closed

6. Does your practice share calls with practitioners who are not otherwise associated with your facility? ☐ Yes ☐ No
If yes, please list: ______________________________

7. Are there any practitioners that provide services at an outreach location? ☐ Yes ☐ No
If yes, please list: ______________________________

8. Are there any practitioners at this facility who do not accept new members? ☐ Yes ☐ No
If yes, please list: ______________________________

H. ADDITIONAL LOCATION(S)

Copy pages 5-7 and complete for each additional practice location associated with the primary facility.

1. Legal name:____

   ***IMPORTANT:** This should be the business name you use to file income to the IRS. (This is also the first line of the **W-9 Form**.)*

2. DBA name: ____

   *This should be the name you are doing business as. (This is also the first line of the **W-9 Form**.)*

3. Federal tax ID #: ____

   If different from Section A, #2

4. Physical address: ____

5. City, state, zip: ________________________ 6. County: ____________________

7. Telephone: ________________________ 8. Fax: ____________________

   *This is the number that will be listed in the **Provider Directory**.*

9. Billing address: ____

   *This is the address to which remittances and correspondence will be sent. This should be the address that appears in Box 33 of the **CMS 1500** and Field 1 of the **UB92**.*

10. Mailing address: ____

11. Email address: ____

12. Website address: ____

13. Are you currently enrolled as a Medicaid provider with the State of Minnesota? ☐ Yes ☐ No

14. Are you currently enrolled as a Medicare provider with the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No

15. NPI #: ________________________ 16. UMPI #: ________________________

I. CONTACT INFORMATION FOR ADDITIONAL LOCATION(S)

Provide the following information for contact people at your facility.

TITLE	NAME	TELEPHONE	EMAIL ADDRESS
a. Administrator/ Facility Site Manager			
b. Business/Billing Office Manager			
c. Director of Nursing/ Nursing Supervisor			
d. Medical Director/ Chief of Staff			
e. Credentialing			

J. SERVICES AVAILABLE AT ADDITIONAL LOCATION(S)

1. Check any service that is provided at this facility. If the service is provided at the facility but billed by another entity, provide the name of the billing entity. If the service is not listed, please check "Other" and list.

- ☐ Acupuncture (by MD or supervised by MD)
- ☐ Ambulatory Surgery
  - ☐ Freestanding Surgery Center
- ☐ Audiology
- ☐ Behavioral Health
  - ☐ CTSS Certified*
- ☐ Case Management
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Child Care
- ☐ Chiropractor
- ☐ Dental
- ☐ Dialysis
- ☐ Diabetes Education
- ☐ Dietician/Nutrition
- ☐ DME (please complete attached checklist on pages 10-11)
- ☐ Eyewear
- ☐ Fitness Professional
  - ☐ Exercise Specialist
- ☐ Hearing Aid Center
- ☐ Home and Community Based Services (HCBS)
- ☐ Home Health Care
  - ☐ Medicare Certified*
- ☐ Hospice
- ☐ Language Interpreter (on-site)
  Language(s) ______________ ________________________
- ☐ Mammography
- ☐ Midwifery
- ☐ Nuclear Medicine
- ☐ Mobile Lithotripsy
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Orthotics
- ☐ PCA
- ☐ Pharmacy
  - ☐ MTMS Certified**
- ☐ Physical Therapy
- ☐ Podiatry
- ☐ Prosthetics
- ☐ Radiology
- ☐ Radiation Therapy
- ☐ Skilled Nursing Facility
- ☐ Speech Therapy
- ☐ Swing Beds
- ☐ Telemedicine
- ☐ Telephonic Interpretation
- ☐ Transportation
  - ☐ Ambulance Service
  - ☐ Common Carrier Transportation
  - ☐ Special Transportation Services
- ☐ Wellness Provider
- ☐ Other *(list below):*
  a. ____________________________
  b. ____________________________
  c. ____________________________

***You must provide a copy of the facility's current certificate.**
****You must provide a copy of the current Medication Therapy Management Services (MTMS) certification of the practitioner.**

2. Is your facility a medical clinic? ☐ Yes ☐ No
   If yes, which do you provide? ☐ OB/GYN ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

3. Does your facility have an age restriction in administering care to members or members? ☐ Yes ☐ No
   If yes, what is the age restriction? (For example, 18 and under only.)

4. Do you provide "in-house" laboratory services? ☐ Yes ☐ No
   If yes, is the lab CLIA certified? **(If CLIA certified, you must provide a copy of the most current CLIA certificate.)**

5. **Do you employ any practitioners who will bill for their professional services through this entity?** ☐ Yes ☐ No
   If yes, submit a ***Minnesota Universal Credentialing Application*** or an ***Exercise Specialist Credentialing Application*** for each practitioner and provide a current practitioner list with title and specialty, NPI/UMPI number, and his/her employment status (employed or non-employed [e.g., outreach]). Credentialing applications can be found on the PrimeWest Health website in the *Partners & Providers* section under *Helpful Links*.

K. EMERGENCY ROOM / URGENT CARE – Hospitals Only

Provide details of how members access care at your hospital.

1. Is the ER open 24 hours/day and 7 days/week?
   ☐ Yes
   ☐ No
   If no, indicate when it is not open:

2. Does the hospital provide Urgent Care hours (separate from the ER)?
   ☐ Yes
   ☐ No
   If yes, please complete the grid at right:

3. URGENT CARE HOURS	FROM—TO
Monday	–
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

L. CALL COVERAGE AND OFFICE HOURS FOR ADDITIONAL LOCATION(S)

1. Please indicate how members of your facility are instructed to access care when the primary clinic is not open. Check as many as apply.

- ☐ Answering machine directs members how to access care – no “live” person answering
- ☐ Answering service directs members how to access care – “live” person answering, but no medical advice given
- ☐ Answering service directs members how to access care and has nurses available to answer medical questions
- ☐ Members seen after hours when necessary by on-call clinic physician at clinic or hospital
- ☐ Members referred to hospital emergency room (ER) and seen by ER physician
- ☐ Other *(describe)*: ______________________________

2. Does your facility provide extended care hours? ☐ Yes ☐ No
   If yes, please fill out hours in section 4 in the grid below.

3. REGULAR OFFICE HOURS	FROM—TO	
Monday	–	☐ Closed
Tuesday	–	☐ Closed
Wednesday	–	☐ Closed
Thursday	–	☐ Closed
Friday	–	☐ Closed
Saturday	–	☐ Closed
Sunday	–	☐ Closed

4. EXTENDED CARE HOURS	FROM—TO
Monday	–
Tuesday	–
Wednesday	–
Thursday	–
Friday	–
Saturday	–
Sunday	–

5. HOLIDAY HOURS	FROM—TO	
New Year’s Day	–	☐ Closed
Martin Luther King Day	–	☐ Closed
President’s Day	–	☐ Closed
Memorial Day	–	☐ Closed
July 4th	–	☐ Closed
Labor Day	–	☐ Closed
Thanksgiving	–	☐ Closed
Christmas Day	–	☐ Closed
Other: ______________	–	☐ Closed

6. Does your practice share calls with practitioners who are not otherwise associated with your facility? ☐ Yes ☐ No
   If yes, please list: ______________________________

7. Are there any practitioners that provide services at an outreach location? ☐ Yes ☐ No
   If yes, please list: ______________________________

8. Are there any practitioners at this facility who do not accept new members? ☐ Yes ☐ No
   If yes, please list: ______________________________

M. REFERRAL PATTERNS

Clinic Referral Patterns: It is PrimeWest Health's goal to allow practitioners to retain as many usual referral patterns as possible. To assist us in contracting efforts, we are asking that you please provide names of the organizations/providers where you refer members for services you are not able to provide at the local clinic. You may list more than one in each section if you wish.

Specialty	Name	City
Hospital used by most physicians at clinic		
Tertiary services (Hospital)		
Trauma		
Burns		
Preterm Labor		
Complicated pregnancies		
Preterm infants		
Cardiology		
Rheumatology		
Pulmonology		
Gastroenterology		
Oncology		
Urology		
Dermatology		
Orthopedics		
Ophthalmology		
ENT		
Neurology		
Surgery		
Radiology		
Dialysis		
PT, OT, ST		
Home Health services		
Long-Term Care/SNF		
DME		
Mental health treatment		
Chemical dependency treatment		
Other		

N. NPI/UMPI REQUEST/VERIFICATION FORM

If your facility has an NPI/UMPI for any of the following, please enter it in the appropriate area.

Hospital:____ Clinic:____

Durable Medical Equipment (DME):____

Skilled Nursing Facility (SNF):____

Long-Term Care/nursing home:____

Swing bed:____ Emergency room:____

Hospice:____ Home Health services:____

Pharmacy:____ Dental:____

Anesthesia:____ Behavioral health:____

Chiropractor:____ Transportation:____

Home and Community Based Service (HCBS):____

Vision:____

Other:____

____

O. ACCOMMODATIONS – To be completed by ALL facilities

Does your facility have:

- ☐ Yes ☐ No Mechanical lifts
- ☐ Yes ☐ No Bariatric lifts
- ☐ Yes ☐ No Adjustable exam tables
- ☐ Yes ☐ No Adjustable X-ray tables
- ☐ Yes ☐ No Scales for members with disabilities (e.g., scales with rails)
- ☐ Yes ☐ No Bariatric scales
- ☐ Yes ☐ No Scales that accommodate wheel chairs
- ☐ Yes ☐ No Parking lot access for members with disabilities
- ☐ Yes ☐ No Handicapped parking spots that are wider to accommodate a side lift system in vehicles
- ☐ Yes ☐ No Family restrooms that are private with complete facilities, toilet and sink

How far is the distance to public transportation? ______________________________

P. DME CHECKLIST – To be completed by ALL DME providers

Home delivery and maintenance:

What is the response time to new requests for general DME?______________________________

- ☐ Yes ☐ No Do you offer home delivery for wheel chair batteries?
- ☐ Yes ☐ No Do you offer home delivery for oxygen?
- ☐ Yes ☐ No Do you offer home delivery for respiratory equipment?
- ☐ Yes ☐ No Do you offer home delivery for other items that are critical to maintaining a stable and maximum level of functioning for members with disabilities?

What is the time frame for expedited home delivery?______________________________

- ☐ Yes ☐ No Do you provide equipment education or instruction upon delivery?
- ☐ Yes ☐ No Do you offer equipment set up to accommodate member's medical specifications?
- ☐ Yes ☐ No Do you provide equipment maintenance?

How far will you travel for delivery and/or maintenance?______________________________

- ☐ Yes ☐ No Can a member call with delivery and/or maintenance questions?
- ☐ Yes ☐ No Can a member call with delivery and/or maintenance questions after hours or on holidays?
- ☐ Yes ☐ No Do you provide equipment maintenance after office hours or on holidays?
- ☐ Yes ☐ No Do you provide preventive maintenance?
- ☐ Yes ☐ No Do you provide loaner equipment while a member's DME is being serviced?
- ☐ Yes ☐ No Is the loaner equipment of equal or better quality than the DME being serviced?
- ☐ Yes ☐ No Do you provide specialty items for members with disabilities?

What is the response time to specialty DME requests?______________________________

- ☐ Yes ☐ No Do you provide adequate supplies of general durable medical equipment for the timely administration of services to meet the needs of members with disabilities?

Please select all services and/or products that you provide:

Bath Safety

- ☐ Bath Lifts
- ☐ Bathing Aids – Hygiene
- ☐ Commodes and Accessories
- ☐ Grab Bars
- ☐ Raised Toilet Seats
- ☐ Shower Chairs & Transfer Benches
- ☐ Toilet Aids
- ☐ Toilet Seat Lifts

Bedroom Aids

- ☐ Bed Rails
- ☐ Overbed Tables

Diabetes Supplies

- ☐ Accessories
- ☐ Blood Glucose Meters
- ☐ Diabetic Test Strips

Diagnostic Products

- ☐ Blood Pressure Monitors

Electrotherapy

- ☐ Electrodes
- ☐ EMS Muscle Stimulators
- ☐ TENS

Hearing Devices

- ☐ Amplified Phones
- ☐ Headphones
- ☐ Personal Amplifiers

IV Infusion

- ☐ Blood Collection
- ☐ Infusion Pumps
- ☐ Infusion Sets
- ☐ IV Catheters
- ☐ IV Dressings
- ☐ IV Flush
- ☐ IV Poles

(DME checklist continued on next page)

P. DME CHECKLIST *continued*

Low Vision Aids
- ☐ Bathroom Mirrors
- ☐ Big Button Remotes
- ☐ Magnifiers
- ☐ Talking Products

Mobility Aids
- ☐ Access Ramps
- ☐ Canes and Crutches
- ☐ Hospital Beds
- ☐ Knee Walkers
- ☐ Lift Chairs
- ☐ Medical Walkers
- ☐ Mobility Scooters
- ☐ Member Lift & Transfer
- ☐ Rollators
- ☐ Scooter Lifts
- ☐ Wheelchairs

Needles and Syringes
- ☐ Accessories
- ☐ Needles
- ☐ Syringes
- ☐ Syringes with Needles

Orthopedics
- ☐ Compression Stockings
- ☐ Elbow
- ☐ Foot and Ankle
- ☐ Hip
- ☐ Knee
- ☐ Lower Back and Abdomen
- ☐ Neck
- ☐ Pillows and Wedges
- ☐ Socks
- ☐ TED Anti-Embolism Stockings
- ☐ Upper Back and Shoulder
- ☐ Wrist and Hand

Ostomy Supplies
- ☐ 1 Piece Closed
- ☐ 1 Piece Drainable
- ☐ 1 Piece Urostomy
- ☐ 2 Piece Closed
- ☐ 2 Piece Drainable
- ☐ 2 Piece Flanges & Skin Barriers
- ☐ 2 Piece Urostomy
- ☐ Accessories
- ☐ Faceplates
- ☐ Ostomy Deodorants & Cleaners
- ☐ Ostomy Irrigation
- ☐ Ostomy Pastes, Powders, & Rings
- ☐ Ostomy Supports
- ☐ Skin Barriers

Oxygen Therapy
- ☐ Air Purifiers
- ☐ CPAP Machines & Accessories
- ☐ Nebulizers
- ☐ Portable Oxygen Concentrators
- ☐ Pulse Oximeters

Personal Protection
- ☐ Accessories
- ☐ Nitrile Gloves
- ☐ Powder Free Latex Gloves
- ☐ Powdered Latex Gloves
- ☐ Protective Wear
- ☐ Sharps – Needle Disposal
- ☐ Sterile Exam Gloves
- ☐ Sterile Surgical Gloves
- ☐ Vinyl Powder Free Gloves

Tracheostomy Care
- ☐ Suction Catheters
- ☐ Suction Pumps
- ☐ Tracheostomy Accessories
- ☐ Tracheostomy Cleaning
- ☐ Tracheostomy Humidification
- ☐ Tracheostomy Tubes

Urinary Incontinence
- ☐ Baby Diapers
- ☐ Bed Wetting
- ☐ Disposable Briefs
- ☐ Disposable Pads – Liners
- ☐ Disposable Pants
- ☐ Disposable Undergarments
- ☐ Disposable Underpads
- ☐ Protective Underwear
- ☐ Pullups
- ☐ Reusable Briefs
- ☐ Reusable Underpads

Urologicals & Catheters
- ☐ Accessories
- ☐ Bedside Drainage Bags
- ☐ Catheter Trays
- ☐ Deodorizers
- ☐ Disposable Leg Bags
- ☐ Foley Catheters
- ☐ Intermittent Catheters
- ☐ Irrigation
- ☐ Latex External Catheters
- ☐ Non Latex External Catheters
- ☐ Reusable External Catheters
- ☐ Reusable Leg Bags
- ☐ Touchless Catheters
- ☐ Tubing & Connectors
- ☐ Urinals and Bedpans

Wound Care
- ☐ Adhesive Bandages
- ☐ Alginate Dressings
- ☐ Attachment Devices
- ☐ Closure Tapes
- ☐ Composite Dressings
- ☐ Compression Bandages
- ☐ Drainage Collectors
- ☐ Foam Dressings
- ☐ Gauze Pads
- ☐ Gauze Rolls
- ☐ Gauze Sponges
- ☐ Hydrocolloid Alginate Dressings
- ☐ Hydrocolloid Dressings
- ☐ Hydrogel Dressings
- ☐ Impregnated Gauze
- ☐ Miscellaneous
- ☐ Non Adherent Pads
- ☐ Non Woven Pads
- ☐ Non Woven Rolls
- ☐ Non Woven Sponges
- ☐ Odor Absorbent Dressings
- ☐ Silicon & Collagen Dressings
- ☐ Sodium Chloride Dressings
- ☐ Tapes & Adherent Wraps
- ☐ Transparent Dressings
- ☐ Tubular Bandages & Gauzes
- ☐ Wound Absorbers
- ☐ Wound Cleansers

Q. DOCUMENTATION

Please attach the following documents:

- ☐ State Facility License
- ☐ Professional Liability Certificate of Insurance, showing coverage amount and dates *(You may refer to the Provider Manual located on our website for coverage requirements.)*
- ☐ General Liability Certificate of Insurance, showing coverage amount and dates *(You may refer to the Provider Manual located on our website for coverage requirements.)*
- ☐ Practitioner list as referenced in #5 on page 3 and 6 of this form
- ☐ W-9 form
- ☐ Other miscellaneous documents that were requested throughout the form if applicable (e.g., CLIA Certificate)

R. CONTRACT SIGNOR STATEMENT

I certify that the information provided on this form is true and correct. I will notify the PrimeWest Health credentialing and network department with any additions/changes to the information.

Contract signor name (print)	Title
Contract signor signature	Date
Telephone number ( )	Email address