SAGAMORE HEALTH NETWORK®

SIMPLY THE BETTER CHOICE.

New Ancillary Facility Questionnaire

*******THIS IS NOT A CREDENTIALING APPLICATION*******

This form can be completed online and printed, or you may choose to print a blank form.

Date: _____

Contact Information:

Contact Name (First): _____(Last): _____

Contact Address: _____

Contact City State Zip: _____

Contact Phone: _____

Contact FAX: _____

Contact E-Mail Address: _____

Facility Information:

Legal Name: _____

Tax Identification Number: _____

NPI Number: _____

Address: _____

City, State, Zip: _____

County: _____

If there are multiple locations, please attach a separate list.

Billing Information:

Provider name on CMS/1500 (Box 33) or CMS 04 (Box 1)

_____ _____

Address: _____

City, State, Zip: _____

Telephone Number: _____

Contact Name: _____

Additional Information:

Specialties: _____

When did facility open? _____

Ownership: _____

Facility Web Site Address: www: _____

Please identify all other major network contracts for this facility by placing a check mark in the box next to the name:

☐Anthem ☐Beech Street ☐ Cigna ☐ Encore ☐ IHN ☐PHCS

☐SIHO ☐ UnitedHealthcare ☐ Other: _____

Is the facility Medicare Certified? Yes ☐ No ☐

Does the facility carry Malpractice Liability Coverage? _____

What is the geographic service area? If not statewide, list the counties:

_____

_____

What form is used to file claims? CMS/1500 ☐ CMS/04 ☐

Are claims filed electronically? _____

Is this facility affiliated with any hospital(s)? If yes, please list: _____

_____

Requested Items:

- W-9
- Claim Sample

Fax to:
Ancillary Contracting Specialist
317-573-2799

Mail to:
Sagamore Health Network, Inc.
Attn: Ancillary Contracting Specialist
11595 N. Meridian Street, Suite 600
Carmel, IN 46032

_____
Print Name

Print Form