Letter of Interest – Facility

Name of Facility: ____

Federal Tax ID # (TIN): _____________________________ (Please attach a copy of your W-9 form)

Facility NPI #: _____________________________ Medicare Certification #: ______________________

1. Facility Address:
   Physical: ____
   Billing: ____
   Mailing: ____
2. Scheduling Phone: _____________________ Authorization Fax: _____________________
3. Primary Contact Name and Title: ____
4. Primary Contact Email Address: ____
5. Is there a freestanding ambulatory surgery attached to the same TIN? Yes No
   If yes, please provide the Medicare record number: ________________________________
6. Is there a skilled nursing facility attached to the same TIN? Yes No
   If yes, please provide the Medicare record number: ________________________________
7. Are there swing beds in or attached to the same TIN? Yes No
   If yes, please provide the Medicare record number: ________________________________
8. Is there a rehabilitation unit attached to the same TIN? Yes No
   If yes, please provide the Medicare record number: ________________________________
9. Is there a hospice attached to the same TIN? Yes No
   If yes, please provide the Medicare record number: ________________________________
10. Is there a home health attached to the same TIN? Yes No
    If yes, please provide the Medicare record number: ________________________________
11. Is there an inpatient behavioral health unit attached to the same TIN? Yes No
    If yes, please provide the Medicare record number: ________________________________
12. Is there a residential treatment center attached to the same TIN? Yes No
    If yes, please provide the Medicare record number: ________________________________
13. Has your Medicare or Medicaid license been revoked for any reason? Yes No
14. Do you file claims electronically? Yes No

Please return this form via fax to 1-888-282-3483 or email to provider.services@mynmhc.org.