REQUEST TO JOIN THE NORTHCOAST NETWORK

Email form to: NCMSO@northcoastgroup.org

Date:

Provider Type: HOME HEALTH HOSPICE HOME INFUSION AMBULATORY INFUSION SUITE OTHER:

Corporate name on W-9:

Company/DBA (if different):

Address:

City: **State:** **Zip:**

What counties do you service:

Additional Locations:

Contact Person: **Provider Website:**

Contact Phone: **Contact Email:**

BUSINESS INFO

Patient Census/month: **Ownership since:** **In business since:**

Tax ID # (TIN): **National Provider ID (NPI):**

Medicare #: **Medicaid #:** **License # (if applicable):**

Accreditation: Joint Commission ACHC CHAP CMS ONLY OTHER:

What services do you provide: HOME HEALTH: SN IVN PT OT ST MSW HHA SPECIALTY
HOSPICE INFUSION OTHER:

Ages Served: PEDS AGES SERVED:

Direct Payer Contracts ANTHEM MMO MYNEXUS OTHER:

Where do you receive your referrals?

Why do you want to join the NorthCoast Network?

How did you hear about the Network?

CREDENTIALING COMMITTEE ONLY - NOTES:

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5 STAR RATING (Home Health): **VERIFIED (accred/etc.):**

INVITE: CJ
EC
BCF
LM
BJ

Comment: CJ
EC
BCF
LM
BJ

FINAL: