FACILITY/ANCILLARY NETWORK INTEREST FORM

Office Contact Information

Date:_____ **Name:**_____ **Email:** _____
Phone: (___) _____ **Fax: (___)** _____
Address: _____ **City:**_____ **State** _____

Facility/Ancillary Information

Corporate Name: _____**Operating (DBA) name:**_____
NPI#: _____**Tax ID#:** _____ **Medicare #:** _____ **Medicaid #:**_____
Are you accredited ☐ **Yes** ☐ **No If yes, list the accrediting entity:**_____

Service Locations

(*If you have more than 2 locations, please attach the additional location information)

LOCATION 1:
Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____
Phone: _____ **Fax:** _____ **County Located:** _____
Office Hours: _____
Counties Serviced: _____
LOCATION 2:
Address: _____ **City:** _____ **State:** ___ **Zip Code:** _____
Phone: _____ **Fax:** _____ **County Located:** _____
Office Hours: _____
Counties Serviced: _____

Facility/Ancillary Specifications

Entity Type/Services:

☐ Hospital	☐Orthotics/Prosthetics
☐ DME	☐ Outpt PT/OT/Rehab
☐ Infusion	☐ Psychiatric Inpt/Outpt
☐ Hospice	☐ Speech Therapy
☐Clinical Lab	☐ Rural Health Clinic
☐ Skilled Nursing Facility	☐ Home Health
☐ Dialysis Center	☐ Cardiac Monitoring
☐ Surgery Center	☐ Urgent Care

Other: _____

Please make sure this form is completely filled out and legible. Submission of this form does not guarantee participation in the network, all decisions are based off on network need and Credentialing factors. Please submit the completed form to Providerrelations@leonhealth.com