Select Health Facility/Vendor Credentialing Request

Today's Date ____________________

Provider Details

Provider Legal Name ____________________

Provider dba ____________________

Provider Type/Services ____________________

NPI ____________________ TIN ____________________

Contact Name ____________________

Contact Phone ____________________ Contact Email ____________________

Primary Location*

Physical address ____________________

City ____________________ State ____________ Zip ____________

Area Code/Phone # ____________________ Area Code/Fax # ____________________

Correspondence address ____________________

City ____________________ State ____________ Zip ____________

Area Code/Phone # ____________________ Area Code/Fax # ____________________

Billing address ____________________

City ____________________ State ____________ Zip ____________

Area Code/Phone # ____________________ Area Code/Fax # ____________________

Servicing Locations/Counties

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***Additional Locations (Please attach a facility roster.)**

Attachments (Please check all applicable boxes)

CLIA (e.g., Hospitals, SNFs, & Labs)	W-9
State Business License(s)	Liability Insurance Certificate
Accreditation Certificate/Certification Information If not accredited, provide applicable Annual State Surveys	Drug Enforcement Administration (DEA) Certificate (e.g., Hospitals with Pharmacy)
Medicare Certification or letter from CMS	Number
Medicaid Certification or letter from state	Number

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