

# Facility Data Intake Form

Please email completed form to  
**delawareprovidernetwork@amerihealthcaritas.com**  
or fax it to **1-877-759-6251**.

Date completed: \_\_\_\_\_

## Facility information

Facility name:		Facility type:			
		<input type="checkbox"/> SNF	<input type="checkbox"/> Dialysis center	<input type="checkbox"/> Durable medical equipment	
		<input type="checkbox"/> PERS	<input type="checkbox"/> Home and community-based services		<input type="checkbox"/> Laboratory
		<input type="checkbox"/> AIDS CM	<input type="checkbox"/> Home health	<input type="checkbox"/> Radiology	
Doing business as (DBA) name, if applicable:					
Provider group TIN:			Provider group NPI:		
Primary contact name:	Primary contact phone:	Primary contact fax:	Primary contact email:		

## Billing information

Group pay to address:	City:	State:	ZIP:
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Facility locations									
	Facility name	Street address	City	State	ZIP	Phone	Fax	Office hours	Handicap accessible
Location 1									<input type="checkbox"/> Yes <input type="checkbox"/> No
Location 2									<input type="checkbox"/> Yes <input type="checkbox"/> No
Location 3									<input type="checkbox"/> Yes <input type="checkbox"/> No
Location 4									<input type="checkbox"/> Yes <input type="checkbox"/> No
Location 5									<input type="checkbox"/> Yes <input type="checkbox"/> No