

**PROVIDER NETWORK APPLICATION**

Corporate Name on W-9:

Agency DBA Names (if different than Corporate Name):

Please select type of Agreement: Home Health:       Hospice:

(If you are interested in both, please complete a separate form for home health and hospice)

Corporate Address:

Corporate Phone:       Corporate Fax:

Contact Name:       Contact Title:

Contact Email (Please use business email address):       Contact Phone:

|  |
| --- |
| Provide full name and address of location(s) to be credentialed (please list all that apply):           Administrator Name:      Administrator Phone:      Administrator Email (Please use business email address):       |

**GENERAL BUSINESS INFORMATION:**

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| --- |
| Date Established:       Total Gross Revenue for past 12 months:      Medicare #:       Medicare Certification mo/yr:       Medicaid #:      Tax ID # (TIN):       NPI #:       Accrediting Organization:      Current Medicare Star Ratings:       |
|  |
| Total Average Daily Census:       Average # New Patient starts per month:      Full time employees:       Part time/Per diem employees:      Payer Mix: Traditional Medicare %:       Managed Care %:       Medicaid %:      Other % (please describe):       |

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| --- |
| Does your agency bill electronically?:      Centralized billing or Individual billing by location:      Centralized Intake/Authorization or individual by location:      Name of Sub-contracted Billing company, if applicable:       Name of Clearinghouse:      Confirm your agency can bill electronically through Availity in batch claim format (this is a mandatory requirement).       |

**SERVICES:**

Counties Serviced:

**Services Provided**:

      SN       PT       OT       ST       HHA       IVRN       LISW       PEDS

      HOSPICE       Other (please describe):

**Specialty Programs**:

|  |  |  |
| --- | --- | --- |
| [ ] Behavioral Health  | [ ] Diabetic Management  | [ ] Pain Management  |
| [ ] Cardio/Pulmonary | [ ] Specialty Infusion | [ ] Other, please describe:  |
| [ ] Wound Care | [ ] Orthopedic Management  |       |

**PAYER REVIEW:**

Any current payer agreement you have, please list:

Any payers NOT accepted, please detail:

**Referral Sources:**

Please list your top three referral sources:

Why do you want to join CSI Network Services?

How did you hear about CSI Network Services?

**Form Completed by (Name, Title, Company)**:

**Date Completed**:

Thank you for your interest in CSI Network Services. Once you have completed this form, please email to agencyupdategroup@optioncare.com. Your information will be reviewed by our Network Department and one of our Network representatives will contact you.

**CSI Network Services Contracting Department………………440-717-1700 Option #6**