

Provider Contact & Site Information For CMHC System

1. Please complete all corporate information requested on page one for your agency.
2. Complete one copy of page two for **each non-residential** site with all information requested for each site.
3. If you offer residential services, also complete page three with all information requested for each residential site. Please fax completed forms to (252) 514-2744

Page 1—Corporate Information

Provider Corporate Contact Information	
Agency Name:	
Agency federal tax id #	
For Profit / Not for Profit Status?	
Agency Mailing Address: <i>(primary address)</i>	
Agency Street Address: <i>(physical address)</i>	
Agency Phone Number:	
Agency Fax Number:	
Agency Corporate Contact:	
Corporate Contact Phone Number:	
Corporate Contact email address:	
Corporate Contact fax number:	
Corporate Contact Mailing address:	
Agency Primary Contact:	
Contact Email Address:	
Services contracted to provide: <i>(procedure codes)</i>	
Agency Claims Contact:	
Claims Contact Phone Number:	
Claims contact email address:	
Agency Finance Officer:	
Finance Officer Contact Number:	
Finance Officer email address:	
Payment Address: <i>(address to mail checks)</i>	

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For CMHC System**

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4. Please include copies of **all licenses** for any sites you operate.

Page 2— Non-Residential Services

Provider Site-Specific Contact Information	
Site Contact Name:	
Local Street Address: <i>(physical site address)</i>	
Local Phone Number:	
Local Fax Number:	
County where site is located:	
Services provided at this site: <i>(list procedure codes)</i>	
Is this site direct enrolled with DMA?	Yes/ No
If so, attach agreement	
NPI #:	
Taxonomy code:	
Is this site licensed?	Yes/No
If so, list license #:	
After Hours Contact Name:	
After Hours Contact Number:	
* Attach copy of license and Medicaid Direct Enrollment	

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Page 3-- Residential Services

Residential Facility Contact Information Form						
<i>If you prefer to use the same facility contact name and phone number as the main or home office contact, please indicate that by placing that persons name and phone number in the spaces below. Otherwise, please place the name and phone number of the person at the facility you deem appropriate to direct any questions or correspondence to.</i>						
Provider Agency Name:						
	Name of Facility	Contact Person at Facility	Facility Street, City Address	Facility Phone #	# of Beds	Facility License Number
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						