

Nursing Facility Demographic Information Form

Please complete one form per facility. Complete all fields to avoid a delay in processing.

New facility Change of ownership Other update(s): _____

| | | |
|---|--------|---|
| Facility name (DBA): | | Tax ID: |
| Legal/tax name: | | NPI: |
| Taxonomy code(s): | | Provider type: <input type="checkbox"/> NH <input type="checkbox"/> SNF |
| Physical location information | | |
| Address: | | |
| City: | State: | ZIP code + 4: |
| Phone #: | Fax #: | |
| Billing/payment remittance address | | |
| <input type="checkbox"/> Same as physical address. If different, complete section below. | | |
| Address: | | |
| City: | State: | ZIP code + 4: |
| Phone #: | Fax #: | |
| Facility contacts | | |
| Administrator name: | | |
| Email: | Phone: | |
| Parent company name (if applicable): | | |
| Primary contact name: | | |
| Email: | Phone: | |
| Business office manager/billing contact: | | |
| Email: | Phone: | |
| Credentialing contact: | | |
| Email: | Phone: | |
| Fax (for recredentialing requests): | | |
| Contracting contact: | | |
| Email: | Phone: | |
| License information | | |
| HHSC nursing facility license #: | | |
| HHSC Medicaid provider/contract # | | |
| Medicare CCN/PTAN/OSCAR #: | | |
| Is the facility ADA handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Signature | | |
| Printed name: | | |
| Signature: | Date: | |

provider.wellpoint.com/tx/

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

Medicare-Medicaid Plan services provided by Wellpoint Texas, Inc.

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