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: ☐NH ☐SNF
Physical location information		
Address:		
City:	State:	ZIP code + 4:
Phone #:	Fax #:	
Billing/payment remittance address		
☐ 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? ☐ Yes ☐ No		
Signature		
Printed name:		
Signature:	Date:	

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