



Request for Facility Information Form

Please complete this form in it's entirety to begin the credentialing process. You will be notified in writing of our decision. All portions of this form are required fields in order to consider your request.

<u>Facility Information</u>		Today's date:			
Facility Name:			Facility Type:		
NPI Number :			Medicare PIN:		
State License Number :			Accreditations:		
Please provide us with a description of the services you provide and a description of your facility:					
<u>Location Information (please make additional copies and complete information for each location)</u>					
Tax ID:			Office Name:		
Street Address:				Suite #:	
City:		State:	County:		Zip:
Telephone No.:		Fax No.:			
Are you accepting new patients? <input type="checkbox"/> YES <input type="checkbox"/> NO	If approved, would you like this location listed in our directory? <input type="checkbox"/> YES <input type="checkbox"/> NO		Are you currently an E-prescriber? <input type="checkbox"/> YES <input type="checkbox"/> NO		Is this location handicap accessible? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Contact Person :				Phone No.:	
Email Address:					
<u>Correspondence address for mailing purposes:</u>					
Street Address:		Suite #:	City:		State: Zip:
<u>Billing address for remit purposes:</u>					
Street Address:		Suite #:	City:		State: Zip:

Note: If you have already completed your application with CAQH, please ensure that you have authorized AultCare to access your data. Using CAQH does not grant participation or constitute applying for participation with AultCare. Please fax this completed form to the AultCare Credentialing Department at 330-363-6421, e-mail credentialing@aultcare.com, or mail to: AultCare Credentialing Department
PO Box 6910
Canton, OH 44706

Please contact AultCare Credentialing at **330-363-1400** if you have any questions Monday-Friday 8:00 am to 4:30 pm.