Non-Contracted Facility Information

Facility name (legal):

Facility DBA name (if applicable):

Federal tax identification number: NPI/UMPI:

Physical address:

City: State: Zip:

Phone #:

Pay-to address:

City: State: Zip:

Mailing address:

City: State: Zip:

Address where 1099 should be sent (select one):
Physical address Mailing address Pay-to address

Type of facility (check one):

Community Health Clinic

Community Mental Health Center

Rural Health Clinic

Indian Health Services (IHS)

Federally Qualified Health Center (FQHC) – ***include a copy of FQHC rates for your facility*** – Provide Centers for Medicare & Medicaid Services (CMS) Prospective Payment System (PPS) effective date (if applicable)

Critical Access Hospital (CAH) – ***include a copy of CMS CAH rates with this form***

Medicare Online Survey, Certification, and Reporting (OSCAR) #

General Acute Care Hospital – Medicare OSCAR #

Other (describe)

No balance billing the member. By accepting IMCare payments, you agree to only bill or attempt to collect from the member any unpaid amounts on any remittance indicated as "member responsibility". (initial)

Name of person completing form:

Phone #:

Submit this document along with the forms 1 and 2 below. You can fax them to us at 218-327-5545. Form 3 must also be submitted, but must be signed and mailed separately, following the instructions on the form. (Do not be alarmed that it says Prime West in the address. It is our link; it just has to get to them.)

1. ***Internal Revenue Service Request for Taxpayer Identification Number and Certification (W-9)***
2. ***Practitioner National Provider Identifier/Unique Minnesota Provider Identifier (NPI/UMPI) Notification/Request***
3. ***Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) Authorization Agreement Form***