TO:	Provider Relations
COMPANY:	Bluegrass Family Health, Inc.
PHONE:	(800) 787-2680
FAX:	(859) 335-3736
E-Mail:	
DATE	
Pages including face sheet:	1

To receive an **Ancillary Provider** packet for possible participation within the Bluegrass Family Health, please fax/e-mail the following information (for EACH LOCATION) and the requested copies to my attention:

- **Liability Insurance Face sheet (minimum $1,000,000 per claim and $3,000,000 aggregate)**
- **W-9 Form (Request for Taxpayer ID No. and Certification)**
- **Copy of Medicare Assignment Letter/NPI numbers for all providers and facility**
- **State License from appropriate agency and/or Cabinet for Health Services Certificate**
- ACCREDITATION CERTIFICATE
- **List provider(s) who will perform Professional Services for the facility**

For Each Site location:	911 address (Physical Location)	Payment address (same as Box 33 of HCFA 1500)	Mailing Address (For correspondence)
County:			
Practice Name:			
Address:			
City/State/Zip:			
Phone #:			
Fax #:			
Contact Person:			

Type of Services Provided: (i.e. DME, Orthotics, Prosthetics, PT, OT, Diagnostic Testing, Health Department, Ambulatory Surgery Center etc)	

Top most commonly billed HCPC –Codes or CPT-Codes:		

Where to mail contract packet if different from above addresses:

Notice

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