ADDITIONAL LOCATION FORM

Employees Group Insurance Division

NAME OF PRACTITIONER (attach roster if needed)

Last,	First	Middle initial	License type

NAME OF INDEPENDENT HEALTH ORGANIZATION OR FACILITY

IHO or facility name

GENERAL INFORMATION

Primary specialty	Secondary specialty
Tax ID number (attach W-9 form)	Medicare number (if applicable)
NPI type I (individual)	NPI type II (organization)

PHYSICAL ADDRESS – Address, phone number and website will appear on the website provider directory.

Practice name

Street address	City	State	ZIP code

Phone	Fax
Website (for publication)	Practice email (for publication)

CONTACT INFORMATION

Contact name

Phone	Extension	Email

Contact information will be utilized for all legal and contractual notices as defined in sections 12.2 of the provider contract and 11.1 of the IHO and facility contracts. A contact email address must be included. All notices will be sent electronically.

SIGNATURE AND DATE

Authorized signature	Date

FACILITY USE ONLY

CEO/administrator name	Phone	Email
Contracting/managed care name	Phone	Email

RETURN TO EGID BY EMAIL

Email: EGID.NetworkManagement@omes.ok.gov

Attach a completed W-9 form for each TIN, Medicare certification and/or accreditation, if applicable.