HealthChoice
Oklahoma State & Education Employees Group Insurance Board
A Division of the Office of State Finance

OKDRS Oklahoma Department of Rehabilitation Services

DOC Department of Corrections Oklahoma

FACILITY ADDITIONAL LOCATION FORM

Facility Name: _____

Classification: _____ Medicare Number: _____

Federal Tax ID Number: _____ NPI#: _____
(Attach a completed W-9 Form for each TIN)

PHYSICIAL ADDRESS - This address will be listed in the online HealthChoice Provider Directory

Address: _____

_____
(City) (State) (ZIP)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail: _____

MAILING ADDRESS – For Credentialing and correspondence not related to claims

Address: _____

_____
(City) (State) (ZIP)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail: _____

BILLING NAME and ADDRESS – Must match claims exactly

Billing Name (must match claims): _____

Billing Address: _____

_____
(City) (State) (ZIP)

Phone: (_____) _____ Fax: (_____) _____

Contact Person: _____ E-mail: _____

Authorized Signature: _____ Date: _____

Contact Name: _____ Phone: _____

FACILITY CONTACTS:

CEO/Administrator Name: _____ Phone: _____

Contracting/Managed Care Name: _____ Phone: _____

RETURN FAX NUMBER 1-405-717-8977

Updated 5-4-12 JW