

FPN FACILITY/ANCILLARY PROVIDER APPLICATION

Facility/Ancillary Name

Facility/Ancillary Address

City/State/Zip

Telephone Number

Fax Number

Email Address

Billing Address

City/State/Zip

Billing Telephone Number

Billing Fax Number

Type of Services Offered

Facility/Ancillary Hours

Contact Person for Contracting

Contact Telephone Number

Federal Tax ID (attach a copy of IRS tax form)

State License Number (attach copy of state license)

Expiration Date

The following information must be submitted with your application:

1. _____ Completed Facility/Ancillary Provider Application (see above)
2. _____ \$185.00 Application Processing Fee (please make check payable to "Fortified Provider Network")
3. _____ Copy of State License
4. _____ Copy of Accreditation Certificates if available (i.e. JACHO)
5. _____ Copy of IRS Tax Form W-9 (verifying Tax Identification Number)
6. _____ Copy of Certification Liability Insurance (just the face sheet)

Please return the completed application to:

Fortified Provider Network, Inc.

Attention: Contracts Department

8096 N. 85th Way, Suite 103

Scottsdale, AZ 85258