

FPN HOSPITAL APPLICATION

Facility Name Facility website (if applicable)

Facility Address City/State/Zip

Telephone Number Fax Number

Billing Address (attach separate sheet for other locations) City/State/Zip

Billing Telephone Number Billing Fax Number

Type of Services Offered Facility Hours

Contact Person for Contracting Contact Phone # Contact Email address

Federal Tax ID (attach a copy of IRS W-9 tax form)

State License Number (attach copy of state license) Expiration Date

Through which organization(s) is your hospital certified?

The following information must be submitted with your application:

1. _____ Completed Hospital Application (see above)
2. _____ Copy of Certification Liability Insurance (just face sheet)
3. _____ Copy of State License
4. _____ Copy of Accreditation Certificates (i.e. JCAHO)
5. _____ IRS Tax Form W-9 (verifying Federal Tax ID #)

Please return the completed application to:
Fortified Provider Network, Inc.
Attention: Contracts Department
8096 N. 85th Way, Suite 103
Scottsdale, AZ 85258