AlaMed
Workers' Compensation Medical Care Network

P.O. Box 59307 Birmingham, AL 35259 Phone: 205.451.1747 Fax: 205.451.1749
www.alamed.net

Facility Fact Sheet

1. **Provider's Name:** _____

2. **Provider's Specialty**
   Which specialty(s) would you like to be listed in the provider directory?
   _____ _____
   _____ _____

3. **Contact Information**
   Contact Person: _____ Title: _____
   Phone Number: _____ Fax Number: _____
   E-mail Address: _____ Website: _____

4. **Physical Address**
   Street Address: _____
   City, State, Zip: _____
   County: _____
   Phone Number: _____ Fax Number: _____

5. **Billing Address (if different from above)**
   Street Address: _____
   City, State, Zip: _____
   Billing Contact: _____
   Billing Phone: _____ Fax Number: _____

6. **Workers' Compensation/Occupational Medicine Coordinator**
   Name: _____
   E-mail address: _____
   Phone Number: _____ Fax Number: _____

7. **Group Tax I.D. Number:** _____
8. **Group NPI Number:** _____
9. **Universal Medicare Number:** _____

10. **Status of any legal judgments:** _____

AlaMed Holdings, Inc. will maintain a file of each participating facility's credentials. In order to do so, please attach the following documents:

- Copy of current license, registration or certificate
- Copy of current malpractice insurance policy
    - Minimum requirement: $1,000,000 single occurrence, $3,000,000 aggregate
- Copy of the W-9 form that matches the facility name and Tax ID number
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This documentation will need to be updated every year!

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application whether intentional or not-- is cause for automatic and immediate rejection of this application and may result in the denial of panel appointment in the network. Upon subsequent discovery of such misrepresentation, misstatement, or omission, AlaMed Holdings, Inc., may have cause to terminate my panel appointment in the network.

I hereby authorize AlaMed Holdings, Inc. to collect verification of the above-noted credentials and insurance information on my behalf.

_____ _____

Signature Date