AlaMed
Workers' Compensation Medical Care Network

P.O. Box 361722 Birmingham, AL 35236 Phone: 205.451.1747
www.alamed.net

Hospital Fact Sheet

Hospital Name _____

Name of Corporation:

_____

1. **Contact Information (if applicable)**

Contact Person: _____ Title: _____
Phone Number: _____ Fax Number: _____
E-mail Address: _____ Website: _____

2. **Physical Address**

Street Address: _____
City, State, Zip: _____
County: _____
Phone Number: _____ Fax Number: _____

3. **Billing Address (if different from above)**

Street Address: _____
City, State, Zip: _____
Billing Contact: _____

4. **Workers' Compensation/Occupational Medicine Coordinator**

Name: _____
E-mail address: _____
Phone Number: _____ Fax Number: _____

5. **Group Tax I.D. Number:** _____
6. **Group NPI Number:** _____
7. **Universal Medicare Number:** _____

Please include a current W-9 when submitting this form!
If you contract out ER and radiology, be sure to include these W-9's as well.

IMPORTANT

Read Carefully Before Signing.

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

Please email your completed Fact Sheet to: jennifer.hall@alamed.net