Please upload the completed form to:
https://prohcn.com/oon-upload/

Out of Network Service Notification

Please note: A W9 is REQUIRED with submission of your Out of Network Service Notification Form. For multiple upload an agency roster or reload this form.

Health Plan: ______________________________

Agency Information

Agency Name (as filed with IRS)	TIN	
DBA Name (if applicable)	NPI	
Medicare PTAN Number:		
Branch Address		
City	State	Zip
Billing Address		
City	State	Zip

Contact Information

Contact Name	Contact Title	Contact Phone Number
Contact Email		

Branch Information

Branch Phone Number	Branch Fax Number	Authorization Phone Number	Authorization Fax Number
Number of in State Branches	List of Servicing Counties		

Scope of Services

☐Skilled Nursing ☐Occupational Therapy ☐Physical therapy

☐Speech Therapy ☐Medical Social Worker

☐Home Health Aide (must be paired with SN, PT, OT, or ST)

I attest that the information provided within this form is true and accurate.

Please sign here: ______________________