PHCN

PLEASE FAX THIS COMPLETED FORM TO: (877) 327-1519

HOME HEALTH PROVIDER FAX CONFIRMATION FORM

PHCN is committed to protecting member's Protected Health Information (PHI). To prevent disclosure of PHI to unauthorized recipients, PHCN requires confirmation of your phone and fax numbers. **PHCN must receive this completed form prior to faxing authorization notifications.**

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Date of Confirmation: _____	**Name of person completing confirmation form:** _____ **Contact Phone # (in case clarification is needed):**
If you are confirming multiple locations, you may attach a list of the locations, along with the information requested below.	
Provider Branch Name (official W-9 Name):	
DBA Name (if app):	
NPI:	**TIN:**
Branch Address:	**City, State:**
Branch Phone #:	***Please note, all faxes for authorization and/or requests for additional documents will be sent to this fax number.***
Branch Fax #:	

If your company has a central authorization department that will be processing authorization requests for multiple branches, please also complete the information below.

Parent Company Name:	I want all communication for members for the above branch listed to go through the central auth department phone/fax:
Authorization Dept Contact Phone #:	Yes
Authorization Dept Fax #:	No

If you have questions regarding this form, please contact our Provider Relations team at providerrelations@prohcn.com (email) or call (888) 705-5274 (main phone number)

Thank you for your assistance in protecting member's PHI.