WCH Service Bureau, Inc
3047 Avenue U,
Brooklyn, NY 11229,
888-WCHEXPERTS tel.
347-371-9968 fax.
www.wchsb.com

CREDENTIALING INFORMATION FORM

Legal Business Name:
_____

Tax ID: _____ NPI: _____

Operating Since Date _____ **State:** _____

Owner of the TIN: _____

I. Ownership/Individual Managing – Information

Name : _____

SSN: _____ **DOB:** _____

Contact Phone: _____

Fax: _____ **Email:** _____

Type of control:
____ **5% or greater owner** ____ **Partner**
____ **Director/Officer** ____ **Managing Employee**
____ **Other** _____

TYPE OF TESTS OFFERED BY FACILITY (list the CPT Codes or the Names of the Tests)

1.	5.
2.	6.
3.	7.
4.	8.

BASE OF OPERATIONS ADDRESS FOR SUPPLIER:

Address: _____

City, State, Zip: _____

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Office Phone: _____ Office Fax: _____

Contact Name: _____

CORRESPONDENCE ADDRESS/MAILING/BILLING:

Address: _____

City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Contact Name: _____

GEOGRAPHICAL LOCATIONS: Provide the city, state and zip for all locations where portable services will be rendered.

_____

_____

DOCUMENTATION REQUIRED:

- **NPI AWARD LETTER**
- **PROFESSIONAL LINCENSURE/PERMITS**
- **QUALIFICATION LETTER FROM DEPARTMENT OF HEALTH**
- **LETTER AWARDING TAX NUMBER WITH LEGAL BUSINESS NAME**
- **ACCREDITATION LETTER**
- **EQUIPMENT INFORMATION**
- **GENERAL/PROFESSIONAL LIABILITY INSURANCE**
- **CERTIFICATES FROM THE TECHINICIANS**
- **VOIDED CHECK FROM THE BUSSINESS ACCOUNT**
- **PAYMENT TO .GOV FOR MEDICARE ENROLLMENT**
- **MEDICAL SUPERVISOR:**
  - *** LICENSE**
  - *** BOARD CERTIFICATIONS**