SPECIALIZED CARE FOR CHILDREN

PROVIDER AGREEMENT

3135 Old Jacksonville Road, Springfield, IL 62704-6488
Toll Free (877) 791-5170 ● Fax (217) 558-0773

PROVIDER INFORMATION

Name, First: _____ MI: _____ Last: _____

Title: _____ Specialty(s): _____ ☐ Male ☐ Female

Facility Name: _____ FEIN #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

E-mail Address: _____ Contact Person: _____

Nurse Practitioners:

Physician(s) with whom you have a working collaborative agreement: _____

Audiologists:

Do you perform ABR testing for newborns? ☐ Yes ☐ No

Do you perform OAE testing for newborns? ☐ Yes ☐ No

LICENSURE/CERTIFICATION

Profession	License #/ Certificate	State	Expiration Date

ADDITIONAL PRACTICE LOCATIONS

♦ **If applicable, list your additional sites of service. You must include a copy of W-9 and/or insurance certificate if the FEIN or insurance coverage <u>is different</u> than your primary location.**

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ County: _____

FEIN: ☐ Same as Primary Site If not, list FEIN: _____ ♦

Insurance Coverage: ☐ Same as Primary Site If not, list carrier: _____ ♦

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ County: _____

FEIN: ☐ Same as Primary Site If not, list FEIN: _____ ♦

Insurance Coverage: ☐ Same as Primary Site If not, list carrier: _____ ♦

LIABILITY INSURANCE INFORMATION

The University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC) requires that all providers providing services to UIC-DSCC clients maintain professional and general liability insurance, as required by law in Illinois or state of practice.

Provider maintains this coverage and will provide copies of an insurance certificate upon request.

Failure of UIC-DSCC to obtain proof of coverage shall not be deemed to be a waiver of the coverage requirement.

Please check the appropriate box:

☐ **Professional** ☐ **Commercial Provider – Home Modification (Requires copy of insurance certificate)** ☐ **Commercial All Other**

☐ I/designee attest that the information provided is accurate to the best of my knowledge and give UIC-DSCC permission to verify such as needed.

☐ I/designee have reviewed the UIC-DSCC Medical Benefit and Billing guidelines for providers

☐ Provider is not excluded from participation in Medicare, Medicaid or any other federal or State healthcare program.

Provider's/Designee's Signature _____ Date _____