



## **New Account Form Facilities Only**

Please take a moment to help us understand how you currently handle your implants by filling out the following forms.

Please send the completed new account form to your Client Relationship Manager at the contact information below.

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Email: [eweachter@mediplantfunding.com](mailto:eweachter@mediplantfunding.com)

If you have any questions, please do not hesitate to call your Client Relationship Manager. Once the completed forms are received, we will be able to begin processing cases for your facility.

# NEW FACILITY FORM

|   |  |                                     |
|---|--|-------------------------------------|
| Facility Name:  |  |                                     |
| Affiliated with Hospital System: <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                     |
| If yes, what System?  |  |                                     |
| Physical Address:   | Remit to Address for Payments (if applicable): |                                     |
| NPI#:   | Tax ID#:                                       |                                     |
| <b>Implant Areas (circle all that apply):</b>   |  |                                     |
| Neurological, Pain Management   | Spine  | GI                                  |
| Neurological, Other   | Cardiovascular                                 | General                             |
| Orthopedic  | Ophthalmologic                                 | Other:                              |
| <b>Contact Information</b>  |  |                                     |
| Main Office Phone#:   | Back Line or Emergency Phone#:                 | Fax#:                               |
| <b><u>Administrator/Manager</u></b>   | <b><u>Precertification Coordinator</u></b>     | <b><u>Billing/Other Contact</u></b> |
| Name:   | Name:  | Name:                               |
| Title:  | Title:   | Title:                              |
| Direct Phone:   | Direct Phone:                                  | Direct Phone:                       |
| Email:  | Email:   | Email:                              |
| Special Instructions:   |  |                                     |
| <b>Ownership:</b> <input type="checkbox"/> Physician Owned <input type="checkbox"/> Hospital Owned <input type="checkbox"/> Joint Venture |  |                                     |
| Other:  |  |                                     |
| Do you use a billing company: <input type="checkbox"/> Yes <input type="checkbox"/> No  | If yes, who?                                   |                                     |
| Do you use a Management Company: <input type="checkbox"/> Yes <input type="checkbox"/> No   | If yes, who?                                   |                                     |

# NEW FACILITY FORM

Implanting Physician Names (per case volume, highest to lowest)

|   | <b>Physician Name:</b> | <b>NPI#:</b> | <b>Monthly Cases<br/>(or surgery days)</b> |
|---|------------------------|--------------|--|
| 1 |                        |              |  |
| 2 |                        |              |  |
| 3 |                        |              |  |
| 4 |                        |              |  |
| 5 |                        |              |  |
| 6 |                        |              |  |

List Insurance Carriers in order of Implant case volume (highest to lowest)

|   | <b>Carrier Name:</b> | <b>Contract Status<br/>(none, active, negotiation)</b> | <b>Implant Provision<br/>(case rate, carve out)</b> |
|---|----------------------|--|---|
| 1 |                      |  |   |
| 2 |                      |  |   |
| 3 |                      |  |   |
| 4 |                      |  |   |
| 5 |                      |  |   |
| 6 |                      |  |   |