Vendor Contact Specification

Date:_______________

Name of agency:____

Federal ID/SSN:____________________ Website:____________________________________

Personal Svcs Agency______ Home Health Care Agency______ Other______

Address of Agency:____

Phone:______________________________ Fax:___________________________________

Does your agency provide Medicaid PA services?________ EDS #______________________

Check the counties your agency can staff:

Daviess_____ Dubois_____ Greene_____ Knox_____ Martin_____ Pike_____

Please complete all that apply; if info for one contact is the same as another, just specify as such. Thank you!

Local Administrative contact—*THIS PERSON WILL BE CONTACTED WITH ANY COMPLAINTS, CONTRACT QUESTIONS/ISSUES, OR OTHER ADMINISTRATIVE ISSUES*

Name:______________________________ Title:__________________________________

Phone:____________________ Email:____

Corporate contact—*IF SEPARATE THAN ADMINISTRATIVE CONTACT FOR BUSINESS PURPOSES*

Name:______________________________ Title:__________________________________

Phone:____________________ Email:____

Referral contact—*THIS PERSON WILL BE CONTACTED TO MAKE NEW REFERRALS TO YOUR AGENCY*

Name:______________________________ Title:__________________________________

Phone:____________________ Email:____

Staffing contact—*THIS PERSON WILL BE CONTACTED TO DISCUSS STAFFING CONCERNS OR QUESTIONS*

Name:______________________________ Title:__________________________________

Phone:____________________ Email:____

Fiscal contact—*THIS PERSON WILL BE CONTACTED WITH ANY QUESTIONS RELATED TO AGENCY BILLING*

Name:______________________________ Title:__________________________________

Phone:____________________ Email:____

To whom should vendor authorizations be sent?____________________________________

Person completing this form:___________________________ **Title:**____________________