CPT NEW AGENCY QUESTIONNAIRE

427 w 20th St Ste 207
Houston TX 77008

TEL: 713-961-7852
FAX: 713-961-0812

Agency's Information: (PLEASE PRINT YOUR ANSWERS TO ALL QUESTIONS)

Agency Name: _____

Tax ID #: _____

Physical Address: _____

_____

Phone: _____ **Fax:** _____

Billing address if different than above

_____

_____

Phone: _____ **Fax:** _____

Please list all owners of your company?

1. _____ **Title:** _____

Home Address: _____ **(City/State/Zip)** _____

Home Phone #: _____ **Cell #:** _____

2. _____ **Title:** _____

Home Address: _____ **(City/State/Zip)** _____

Home Phone #: _____ **Cell #:** _____

3. _____ **Title:** _____

Home Address: _____ **(City/State/Zip)** _____

Home Phone #: _____ **Cell #:** _____

Agency's Who's Who?

- **Administrator:** _____
- **Assistant Administrator:** _____
- **Director of Nursing:** _____
- **Scheduling and Staffing:** _____
- **Accounts Payables:** _____

General Questions:

- **What type of service you are requesting? (Check all that applies)**

___ PT ___ OT ___ ST ___ MSW

- **Patients' demographics**

___Adults ___Pediatrics

- **Insurance Type: ___Medicare ___Medicaid ___ Private ___other_____.**

- **Please list area(s) of coverage you are requesting services for?**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Trade References:

1. Business Name: _____

Address: _____

Phone #: _____ **Contact Person:** _____

2. Business Name: _____

Address: _____

Phone #: _____ **Contact Person:** _____

Documentation:

a. Has your agency been surveyed by Medicare? If yes please provide the date?

____Yes ____No. Date_____/_____/_____

b. How long your agency has been in business? _____ Years _____Months

c. Please attach a copy of the following documentation:

- ❑ **Medicare Certification**
- ❑ **Business License**

d. What is the total number of employees currently on payroll?

_____

I certify that all the information provided pursuant to the above questions is true and correct to the best of my knowledge:

_____

Name of person filing questionnaire

_____ _____/_____/_____

Signature Date:

Comments

_____

_____

_____

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_____

Office use only

_____

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_____

Note: This questionnaire must be completed entirely before the contract can be processed. There will be a phase period of 3 business days for processing.