Department of Veterans Affairs
HEALTH ADMINITRATION CENTER
Denver, Colorado

Date:
_____
_____
_____

In Reply Refer to:

Subject: Provider File Update

In order to process the claims from your facility, provider information is required. Please complete the following and return it along with a copy of your ***W-9, Request for Taxpayer Identification Number and Certification.*** For each individual Medicare certification, please identify the Medicare certification number and corresponding Tax Identification Number (TIN) in section II. Return this completed form and requested documentation as soon as possible to avoid any further rejections to: ***Health Administration Center, Attn CPD/Suspense Unit, PO Box 65023, Denver, Co 80206-5023***

Section I – Institutional Facility Information

Name & Physical Address of Service:

Telephone No. ( )

Remittance Address (if different from service address)

Telephone No. ( )

Section II – Medicare Certification

Facility Designation				Separate & Discrete *Units*			
	HOSPITAL/FACILITY *(check all appropriate boxes)*	**Medicare No.**	**TIN.**		**Unit** *(check all appropriate boxes)*	**Medicare No.**	**TIN**
	Children's				Drug & Alcohol		
	Gen'l Short-Term				Psychiatric		
	Long-Term Care				Rehabilitation		
	Primary Cancer				Skilled Nursing		
	Psychiatric				Other *(please specify*		
	Rehabilitation						
	Skilled Nursing						
	Sole Community						
	Other *(please specify)*						

Health Administration Center use only:

Claims _____ _____ _____ _____ _____ _____

CHAMPVA
PO Box 65023
Denver CO 80206-9023

Foreign Medical Program
PO Box 65021
Denver CO 80206-9021

Spina Bifida Healthcare Benefits
PO Box 65025
Denver CO 80206-9025