SecureCare

Chiropractor Contract Request Form
Fax: (402) 934-4908
Email: providerservices@securecarecorp.com
Mail to: SecureCare Corp
13215 Birch Drive Ste 200
Omaha, NE 68164

Along with your completed Contract Request form, please submit an Individual Practitioner/Provider Addition and Termination Form for every individual practitioner being added. Your effective date of participation will be communicated to you via a counter-signed copy of the contract from SecureCare. If you have any questions, please contact us at (402) 934-4744 or 1-877-462-4476.

Request Type: ☐ New/Additional Contract Request ☐ Adding an Additional Location

Date:

Legal Name:

Is your business registered under a:

☐ FEIN ☐ SSN FEIN/SSN Number: Tax Exempt: CLIA #

Location 1 Effective Date: NPI/UMPI#:

Doing Business As (DBA):

Physical Address

Address:
City: St: Zip:
Phone #:
Wheel Chair Access
Can you accept mail at this location:
Directory suppressed:
Accepting New Patients*: (Please notify SecureCare if this changes)

Mailing Address
(only complete if you aren't able to accept mail at your physical location)

Address:
City: St: Zip:

Billing Address

Address:
City: St: Zip:
Phone #:

Are you a Medicare certified facility:
Medicare #:

Urgent Care: (if yes, please complete Urgent Care hours below)

*If there are any practitioners at this location that aren't accepting new patients, please attach additional documentation.

Hospital Affiliation:
Hospital Address: City: St: Zip:

Business Hours:

	Open (Mon)	Close	Open (Tue)	Close	Open (Wed)	Close	Open (Thur)	Close
Regular								
Urgent Care								

	(Fri)		(Sat)		(Sun)	
Regular						
Urgent Care						

Has the clinic or facility ever been contracted with Blue Cross before under any NPI/Name or Tax Identification number?

If yes, list NPI or Tax ID #: NPI #: Tax ID #:

Person Completing Form:

Address to Send Contracting Material:

E-Mail Address: Phone #: Fax #:

The Sender of this Form represents and warrants that he/she is authorized to submit these changes on behalf of the Provider.

To add more physical locations please complete page 2 "Site Location Addendum" for each additional site.

Site Location Addendum

Date: Legal Name: FEIN/SSN Number:

Location 2 Effective Date: NPI/UMPI#:

Doing Business As (DBA):

Physical Address

Address:

City: St: Zip:

Phone #:

Wheel Chair Access

Can you accept mail at this location:

Directory suppressed:

Accepting New Patients*: (Notify SecureCare if this changes)

*If there are any practitioners at this location that aren't accepting new patients, please attach additional documentation.

Mailing Address

(only complete if you aren't able to accept mail at your physical location)

Address:

City: St: Zip:

Billing Address

Address:

City: St: Zip:

Phone #:

Are you a Medicare certified facility:

Medicare #:

Urgent Care: (if yes, please complete Urgent Care hours below)

Hospital Affiliation:

Hospital Address: City: St: Zip:

Business Hours:

	Open (Mon)	Close
Regular		
Urgent Care		

	Open (Tue)	Close
Regular		
Urgent Care		

	Open (Wed)	Close
Regular		
Urgent Care		

	Open (Thur)	Close
Regular		
Urgent Care		

	(Fri)
Regular	
Urgent Care	

	(Sat)
Regular	
Urgent Care	

	(Sun)
Regular	
Urgent Care	

Location 3 Effective Date: NPI/UMPI#:

Doing Business As (DBA):

Physical Address

Address:

City: St: Zip:

Phone #:

Wheel Chair Access

Can you accept mail at this location:

Directory suppressed:

Accepting New Patients*: (Notify SecureCare if this changes)

*If there are any practitioners at this location that aren't accepting new patients, please attach additional documentation.

Mailing Address

(only complete if you aren't able to accept mail at your physical location)

Address:

City: St: Zip:

Billing Address

Address:

City: St: Zip:

Phone #:

Are you a Medicare certified facility:

Medicare #:

Urgent Care: (if yes, please complete Urgent Care hours below)

Hospital Affiliation:

Hospital Address: City: St: Zip:

Business Hours:

	Open (Mon)	Close
Regular		
Urgent Care		

	Open (Tue)	Close
Regular		
Urgent Care		

	Open (Wed)	Close
Regular		
Urgent Care		

	Open (Thur)	Close
Regular		
Urgent Care		

	(Fri)
Regular	
Urgent Care	

	(Sat)
Regular	
Urgent Care	

	(Sun)
Regular	
Urgent Care	

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SecureCare

Individual Add Terminate Change Form

Fax to: (402) 934-4908
Mail to: SecureCare
13215 Birch Drive STE. 200
Omaha, NE 68164

Please complete this form when adding or terminating an individual practitioner to your clinic.
If initial credentialing or re-credentialing is required, the Credentialing Department will contact you.
Practitioners may not see patients until the credentialing process has been completed.

If you have any questions, contact Provider Services at (402) 934-4744 or 1-877-462-4476.

Individual Practitioner Information

Date of Request:

Last Name: First Name: Mid Init: Suffix:

Previous Names: Sex: ☐ Male ☐ Female Date of Birth:

Title: Status:

Specialty:

State Medical License/Cert #: NPI/UMPI #:

Please submit a copy of license(s) with this form

Change Practitioner Demographic Data

Effective Date of Change :

New Last Name*: New First Name*:

Please submit a copy of an updated license or legal document along with this form

New NPI/UMPI #: New License/Cert #: New Specialty:

Add/Remove Practitioner

Effective Date: ☐ Add Practitioner to all locations ☐ Term Practitioner from all locations

Practice Location 1 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 1 NPI #:

Location 1 Tax ID #:

Directory suppress: ☐ Add Practitioner

Accepting New Patients: ☐ Term Practitioner

Practice Location 2 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 2 NPI #:

Location 2 Tax ID #:

Directory suppress: ☐ Add Practitioner

Accepting New Patients: ☐ Term Practitioner

Person Completing Form: Signature:

E-Mail Address: Phone #: Fax #:

The Sender of this Form represents and warrants that he/she is authorized to submit these changes on behalf of the Provider.

To add more locations please complete page 2 "Site Location Addendum" for each additional site.

Site Location Addendum

Date of Request: Practitioner NPI #: Last Name:

Practice Location 3 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 3 NPI #:

Location 3 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Practice Location 4 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 4 NPI #:

Location 4 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Practice Location 5 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 5 NPI #:

Location 5 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Practice Location 6 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 6 NPI #:

Location 6 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Practice Location 7 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 7 NPI #:

Location 7 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Practice Location 8 Effective Date:

Clinic/Hosp Name:

Street:

City: St: Zip:

Location 8 NPI #:

Location 8 Tax ID #:

Directory suppress: Add Practitioner

Accepting New Patients: Term Practitioner

Notes or special considerations:

The Sender of this Form represents and warrants that he/she is authorized to submit these changes on behalf of the Provider.