Please upload the completed form to:
https://tangocare.com/oon-upload/

Out of Network Service Notification

Please note: A W9 is REQUIRED with submission of your Out of Network Service Notification Form. For multiple upload an agency roster or reload this form.

Health Plan: _____

Agency Information

Agency Name (as filed with IRS)	**TIN**	
DBA Name (if applicable)	**NPI**	
Branch Address		
City	**State**	**Zip**
Billing Address		
City	**State**	**Zip**

Contact Information

Contact Name	**Contact Title**	**Contact Phone Number**
Contact Email		

Branch Information

Branch Phone Number	**Branch Fax Number**	**Authorization Phone Number**	**Authorization Fax Number**
Number of in State Branches	**List of Servicing Counties**		

Scope of Services

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home Health Aide (must be paired with SN, PT, OT or ST)
- ☐ Medical Social Worker

I attest that the information provided within this form is true and accurate

Please sign here: