

MUTUAL OF OMAHA
MEDICARE INTERMEDIARY
PROVIDER CONTACT AND ADDRESS INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION TO ENSURE THE CORRECT ADDRESSES ARE USED FOR VARIOUS MAILINGS. IF ANY INFORMATION HAS BEEN REPORTED ON THE FORM CMS-855A, INDICATE IN THE AREA BELOW.

FACILITY CONTACT PERSON, TITLE, ADDRESS, PHONE NUMBER (internal use: STAR 1)

HOME OFFICE OR CHAIN NAME, ADDRESS, TELEPHONE, AND CONTACT PERSON, TITLE
(internal use: STAR 2)

CONTACT PERSON AND ADDRESS FOR RATE REVIEWS, COST REPORT REQUEST,
NOTICE OF PROGRAM REIMBURSEMENT, UNDERPAYMENT/OVERPAYMENT LETTERS
(internal use: STAR 3) (Please Note: This should not be a consultant, management
company, etc.)

ADDRESS FOR REMITTANCE ADVICES, CHECKS, AND NEWSLETTERS TO BE SENT (APASS)

CHOW PROVIDERS:
ADDRESS FOR OLD OWNER CONTACT
