



Facility Change Form

****MUST FAX COPY OF W-9****

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone #: _____ Fax #: _____

Contact Person (i.e., Center Admin/Office Manager): _____

Medical Report Contact Person: _____

Phone #: _____ Fax #: _____

Business Hours: M: _____ T: _____ W: _____ Th: _____ F: _____ S: _____ Su: _____

** Tax ID#: _____ Billing Global: _____ Billing Split: _____

Remit Address: _____

City: _____ State: _____ Zip: _____ County: _____

Billing Contact: _____

Phone #: _____ Fax #: _____

MRI Make: _____ CT Make: _____

Model: _____ Model: _____

Magnet Strength: _____

MRI Table Weight: _____ CT Table Weight: _____

Latest Software Version: _____

OTHER SERVICES – PLEASE ATTACH LIST

Return to:

One Call Medical, Inc.

Attn.: Provider Relations

20 Waterview Blvd, PO Box 614

Parsippany, NJ 07054-0614

or

Fax: 973-257-9512

or

Email: providerrelations@onecallmedical.com