

# Network 16 Facility Information Update Form



ESRD ALLIANCE | NETWORK 16

Name of Person Completing this Form	Telephone #	Email	Date

**Instructions:** Use this form to notify the Network of any significant facility changes. Leave blank if information has not changed. For any changes below, the Network requires the following documents:

1. Notification of the change on facility letterhead signed by the Facility Administrator or Medical Director;
2. All fields with an asterisk also require a copy of the CMS Certification letter (\*).

FACILITY DEMOGRAPHICS			
Facility/Provider Legal Name:			
Facility/Provider Doing Business As (DBA) Name:			
<input type="checkbox"/> Same as Legal Name			
*Facility CCN:		Facility NPI#:	
Telephone #:		Fax #:	
*Address: <input type="checkbox"/> *Physical <input type="checkbox"/> Mailing <input type="checkbox"/> Both			
Street		City	State    Zip

FACILITY DETAILS			
<b>Program Type</b>	<b>Location Type</b>	<b>Profit Status</b>	<b>Facility Status: Open</b>
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hospital Based	<input type="checkbox"/> Profit	<input type="checkbox"/> No, permanently closed    Date Closed: _____
<input type="checkbox"/> Transplant	<input type="checkbox"/> Free-Standing	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> No, temporarily closed    Date Closed: _____
	<input type="checkbox"/> Satellite		<input type="checkbox"/> Yes, facility is open    Re-open Date: _____

OWNERSHIP/MANAGEMENT AFFILIATIONS	
*Owned By:	
Other Owner:	Managed By:

SERVICES AND CERTIFICATION INFORMATION: CERTIFICATION TYPE		
<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Dialysis Facility: Hospital	<input type="checkbox"/> Transplant and Dialysis Center
<input type="checkbox"/> Inpatient Care Only	<input type="checkbox"/> Dialysis Facility: Non-Hospital	<input type="checkbox"/> Transplant Center

SERVICES AND CERTIFICATION INFORMATION: STATIONS INFORMATION		
*Certified Stations:	Isolation Stations:	Total Stations Available:

*MEDICARE CERTIFIED SERVICES OFFERED (Select all that apply)			
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/> Home Support (HD)	<input type="checkbox"/> Home Support (PD)	<input type="checkbox"/> Home Training (HD)
<input type="checkbox"/> Home Training (PD)	<input type="checkbox"/> Peritoneal Dialysis	<input type="checkbox"/> Transplantation	

Submit Page 1 of this form to the Network by fax or email

Fax: 206-923-0716 | Email: [data@nw16.esrd.net](mailto:data@nw16.esrd.net)

ESRD Network 16 Northwest Renal Network

4702 42nd Ave SW, Seattle WA 98116 | Phone: 206-923-0714 | Fax: 206-923-0716 | [www.nwrn.org](http://www.nwrn.org)

## Additional Facility Changes

Please note that **all fields below** must be updated in CROWNWeb **by the facility**.

The Network does not update the below fields in CROWNWeb because the facility's CROWNWeb Users have the ability to do so.

### Facility Contact Information

Telephone #:	Fax #:
Facility E-mail	Website

### Backup Facility Information

Facility CCN #1	Facility NPI	Facility/Provider DBA Name
Facility/Provider Address #1	City/State/Zip	Telephone
Facility CCN #2	Facility NPI	Facility/Provider DBA Name
Facility/Provider Address #2	City/State/Zip	Telephone

### Additional Services Offered – Non-Medicare

Accepts Pediatrics	Accepts Transients	CAPD	CCPD
Frequent Dialysis at Home	Frequent Dialysis In-Center	Home IPD	In-Center Peritoneal
Isolation Stations	Nocturnal Hemodialysis	Practices Dialyzer Reuse	Shift starts after 5pm

### Hours and Shifts

*Hours and Shifts	Status (Open/Closed)	Open Time	Closed Time	Number of Shifts
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