

New Facility Information

Please complete ALL fields and FAX to HSAG: ESRD Network 15 at 303.860.8392.

Date Facility Opened: _____

Facility Type: Dialysis Transplant

Facility National Provider Identifier (NPI): _____

Facility Name: _____

Phone Number: _____ Fax Number: _____

Number and Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Parent Company (Owned By): _____

Profit Status: Profit Non-Profit

Location Type: Hospital-Based Free-Standing Satellite Unit

Total Number of Dialysis Stations: _____ Number of Isolation Stations: _____

Services Offered: (check all that apply)

Hemodialysis Home Support (Hemo) Home Support (PD) Home Training (Hemo)
 Home Training (PD) CAPD CCPD Accepts Pediatrics Accepts Transients

Frequent Dialysis (5 or more times/week): In-Center Home

Practices Dialyzer Reuse Shift Starting After 5 p.m. Intercenter PD

MWF Open Time: _____ MWF Close Time: _____ MWF # of Shifts: _____

TThS Open Time: _____ TThS Close Time: _____ TThS # of Shifts: _____

Name of person completing this form: _____

Phone for person completing this form: _____

Email for person completing this form: _____

Questions? Call Network 15 at 303.831.8818