



# Agency Information Form

**ALL INFORMATION ON THIS FORM IS REQUIRED; PLEASE MARK "N/A" IF NOT APPLICABLE**

Agency Name: \_\_\_\_\_ Date: \_\_\_\_\_

NPI#: \_\_\_\_\_ TIN#: \_\_\_\_\_ TPI#: \_\_\_\_\_ DADS Contract#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ EVV Contact Name: \_\_\_\_\_

**EVV CENSUS:** \_\_\_\_\_ **Number of SADs In Use?** \_\_\_\_\_ **Number of Staff to Manage EVV?** \_\_\_\_\_

**CONTACT INFORMATION Security PIN Code used to identify Personnel (REQUIRED) UNIQUE 4 DIGIT NUMBER**

\*Director/Administrator: \_\_\_\_\_ Email: \_\_\_\_\_ PIN Code: \_\_\_\_\_

\*Alternate Administrator: \_\_\_\_\_ Email: \_\_\_\_\_ PIN Code: \_\_\_\_\_

**\*Director/Administrator & Alternate Administrator listed above considered ONLY Personnel with Administrative Rights. (Optional)**  
List additional Personnel authorized to Enable Vesta User(s) or Reset Password(s).

Authorized Personnel Name: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_ PIN Code: \_\_\_\_\_

**VESTA EVV VERSION INFORMATION** New EVV Provider? \_\_\_\_ Yes \_\_\_\_ No

Agency will use the Vesta EVV Only Version

Agency uses or will use a Management System (Third Party Software Integration)

Software: \_\_\_\_\_ Contact Name and Email: \_\_\_\_\_

**PROVIDER AGENCY PROGRAM(S)**

STAR+PLUS  STAR Health  STAR Kids  CLASS  CAS/FC/PHC

**PROVIDER AGENCY OR FMSA PAYORS**

Amerigroup Corporation  Cigna-HealthSpring  United Healthcare  Molina Healthcare  Superior HealthPlan

TMHP/HHS  Aetna Better Health of Texas  Community First Health Plans  Cook Children's Health Plan

BCBS of Texas  Texas Children's Health Plan  Children's Medical Center  Driscoll Children's Health Plan

**PROVIDER AGENCY PILOT PARTICIPATION**

Visit Maintenance Reduction Pilot:  Currently Participating  Interested in Participating? \_\_\_\_ Yes \_\_\_\_ No

GPS Mobile App Pilot:  Interested in Participating? \_\_\_\_ Yes \_\_\_\_ No

Electronic MCO Authorization Pilot:  Interested in Participating? \_\_\_\_ Yes \_\_\_\_ No

Authorized Representative Name (Please Print): \_\_\_\_\_

Title: \_\_\_\_\_ Signature: \_\_\_\_\_

If more than one office location, provide separate list of branches with Complete Address, Census and Tax ID.  
Send completed form via (Fax) 956.412.1464 or (email) info@vestaevv.com