

Agency Information Form

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

Legal Entity Name: _____ Provider Agency FMSA

NPI#: _____ TIN#: _____ TPI#: _____ Provider Contract#: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ EVV Contact Name: _____

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: _____

PROGRAM(s) STAR+PLUS STAR Health STAR Kids

Payer(s) Aetna Amerigroup BCBS of Texas Cigna-HealthSpring Children's Medical
 Community First Cook Children's Driscoll Molina Superior
 Texas Children's United Health Care

PROGRAM(S) CLASS CAS/FC/PHC

Payer HHS/TMHP

Signature Authority Name (Please Print): _____

Signature: _____ Title: _____ Date: _____

Phone : _____

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