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

PROVIDER AGENCY PILOT PARTICIPATION

- **Electronic Authorization Pilot for TMHP/DADS Fee For Service (FFS) Authorizations:**
  Interested in Participating? __ Yes ___No

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