State of Illinois
Department of Human Services

FOID Inpatient Provider Reporting Registration Form

Provider Information

Name: _____

NPI: _____ HFS Medicaid ID: _____

Provider Type: _____

Street Address: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

Additional Provider Data

Number of Licensed Psychiatric Beds in Facility: _____

Hospital Administrator Information

First Name: _____ Middle Initial: _____ Last Name: _____

Phone: _____ Extension: _____

E-Mail Address: _____

Primary Contact Information

First Name: _____ Middle Initial: _____ Last Name: _____

Phone: _____ Extension: _____

E-Mail Address: _____

Hospital Administrator Signature: _____ Date: _____

Primary Contact Signature: _____ Date: _____

To Be Completed by OCAPS

OCAPS Coordinator Signature: _____ Date: _____

Print Form Reset Form