

## Agreement Between

Facility Name	Provider number (required)
AND	
Network 8, Inc.	
The undersigned, on behalf of	
(Fac	ility Name)
hereby joins other Medicare-certified End-Stage Renal D agreeing to participate in the activities of the Network as Department of Health and Human Services regulations.	
It is understood that participation in Network activities is Medicare reimbursement for the provision of End Stage	
The dialysis facility must cooperate with the ESRD Network fulfilling the terms of the Network's current statement o ESRD Network activities and pursue Network goals. Failu CMS.	f work. Each facility must participate in
Signed	
(Authorized Representative of Facility)	<del></del>
Date	
The undersigned acknowledges this document as an agre	eement between
(Facility name)	, and Network 8, Inc.
Signed	
Executive Director, Network 8, Inc.	
Date	

## **Instructions for Completing Facility Agreements**

The Conditions for Coverage, enacted in 2008, require that facility agreements be implemented between each Network and facilities in the Network region.

## Directions:

- 1. Enter the facility name where indicated on the form (typically this is the "doing business as" name).
- 2. Enter the Medicare provider number issued by CMS.
- 3. Re-enter the facility name in the blank following "on behalf of"
- 4. Re-enter the facility name following "an agreement between"
- 5. Print two copies of the form and have them signed by the person authorized by the governing body to execute such agreements.
- 6. Forward two copies of the document to Network 8, Inc. at 775 Woodlands Parkway, Suite 310, Ridgeland, MS 39157. The agreement will be countersigned and one copy will be returned by mail or fax to the requesting person. You can also attached the agreement after completing the on-line application form.