

# NOTIFICATION OF PARTICIPATION IN NEBRASKA TELEHEALTH NETWORK

*(Please refer to the Instructions attached when completing this Form. If you have questions or concerns, please contact your Hub Hospital representative or the Public Service Commission.)*

## Hospital Contact Block

HCP Name:	_____
Federal HCP Number:	_____
Contact Name:	_____ Phone Number: _____
Address:	_____
City:	_____ State: _____ Zip: _____
Hub Hospital:	_____
E-Mail Address:	_____
Service Provider:	_____
Account Number:	_____

## Certification Block:

I certify that I am authorized to submit this request on behalf of the above-named entity or entities, that I have examined this request, and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.

I certify that the telecommunications services that the HCP receives at reduced rates as a result of the HCPs participation in this program, pursuant to 47 U.S.C. Sec. 254 as implemented by the Federal Communications Commission, and NUSF-26 as implemented by the Nebraska Public Service Commission, will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.

I hereby certify that I, my agents, or my assigns will notify the Nebraska Public Service Commission immediately upon the termination of service provided by the underlying telecommunications company, the effective date of that termination, and the party requesting such termination.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Position: \_\_\_\_\_

**Return this Completed Form and all necessary attachments to:**

**Jeffrey L. Pursley, Director  
Nebraska Universal Service Fund Department  
300 The Atrium, 1200 N Street  
Lincoln, NE 68508  
Phone: 402-471-3101  
Fax: 402-471-0214**

**AND**

**Your Service Provider. See Attached List for Contact Information**

**Listing of Telecommunications Carriers  
Participating in the Nebraska Telehealth Network**

**Action Communications**

ATTN: Larry Couch  
315 West 27th Street  
Scottsbluff NE 69361  
Phone: (308) 632-7836

**Galaxy Cablevision**

ATTN: Linda Klipp  
600 and 1/2 Grant Avenue  
York, NE 68467  
Phone: (402) 362-3334  
Fax: (402) 362-4855

**Alltel Communications, Inc.**

ATTN: Cindy Brenning  
P.O. Box 81309  
Lincoln, NE 68501  
Phone (402) 436-4466  
Fax (402) 436-4074

**Hamilton Long Distance**

ATTN: Gary Warren  
1001 12th Street  
Aurora NE 68818  
Phone: 402-694-5101

**AT&T E-Rate Coordinator**

55 Corporate Drive  
Room 33C97  
Bridgewater NJ 08807-1265  
Phone: 1-877-272-2544

**Qwest Communications**

ATTN: Shay Bartruff  
1600 7th Avenue  
Room 506  
Seattle, WA 98191  
Phone: (800) 510-2148

**Dark Fiber**

ATTN: Linda Klipp  
600 and 1/2 Grant Avenue  
York, NE 68467  
Phone: (402) 362-3334  
Fax: (402) 362-4855

**Sprint**

ATTN: Tom Vogle  
1010 South 120th Street  
Omaha, NE 68154  
Phone: 866-501-2213  
Fax: (402) 778-2296

## **Instructions to Complete Notification of Participation in Nebraska Telehealth Network**

### **Hospital Contact Block**

1. HCP Name: Name of the Hospital Participating in the Network.
2. Federal HCP Number: Number assigned to HCP by USAC. If the hospital is not eligible for Federal Support, put "not applicable".
3. Contact Name: Name of the Person responsible for all forms filled with NUSF.
4. Phone Number: Phone Number for Contact Person.
5. Address, City, State, Zip: This is the **physical address** of the HCP.
6. Hub Hospital: Name of the Hub Hospital for which the HCP is primarily connected.
7. E-Mail Address: E-mail Address for the Contact Person.
8. Service Provider: This is the Entity which **bills the hospital**. There can only be **one Entity** listed per form. If the hospital is billed by multiple Entities, you will need to complete a Notification form for each Entity.
9. Account Number: This is the Account Number shown on the Invoice.

### **Certification Block**

Whoever is completing this form for the HCP needs to sign and date the certification block.

**Send the completed form to the Public Service Commission and your Service Provider.  
See "Telecommunications Providers" tab for contact information for your provider.**