Provider Information Sheet

You must complete this form accurately and completely for each provider in your group. Please make copies as needed.

_______	New Enrollment	Complete sections 1, 2 and 3
_______	Inactivate a Provider	Complete section 1 **only**
_______	Add a Provider	Complete sections 1, 2 and 3

SECTION 1

Do you want your account set up as a group/practice or individual provider? GROUP/INDIVIDUAL

Group/Practice Name: ____________________

Providers name (including credentials): ____________________

Provider Specialty: ____________________ SSN: ____________________

Address: ____________________

City: ____________________ State: ____________________ Nine Digit Zip: ____________________

Phone: ____________________ Fax: ____________________

Contact: ____________________ Email: ____________________

State Medical License #: ____________________

SECTION 2

Is the provider credentialed under the group NPI? Yes or No

If you are not credentialed in one of the following, please print "N/A" in the space provided or "pending" if providers numbers are pending.

Payers	Individual #	Group/Organizational #
Type I NPI #:		
Taxonomy Code:		
Medicare (PTAN #):		
Medicaid:		
BC/BS:		
Railroad Medicare (PTAN #):		
Tricare:		
American Specialty Health (ASHN):		

Please attach a list of any additional carriers and provider number you may file claims to.

SECTION 3

How do you want to receive payment for claims? You may choose only one option:

Group Tax-ID ____________ **(OR)** Individual Tax-ID ____________ **(OR)** Provider Social ____________

Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Nine Digit Zip: ____________________

INTERNAL USE ONLY

Account #: ____________________ Ticket #: ____________________ Initials: ____________________