Infinedi
ELECTRONIC DATA INTERCHANGE

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: _____

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