



Request to Establish or Revise a Provider Record

(Subscriber will be paid directly if information is not received within 10 days.)

Please check one:
[] Establishing a new provider record
Please complete the entire form.
[] Revising an existing provider record
Please provide your name, any information that you wish to change, and your signature.

NOTE: If this is a group practice and the physicians are using their personal social security numbers for federal tax purposes, complete a separate form for each individual.

Provider Name (Title/Degree):

Social Security #: Medicare Provider #:

Federal Tax ID # (TIN or EIN): (If TIN change, effective date of new TIN)

*Type 1 NPI (National Provider Identifier) #:

Business or Facility Name:

*Effective date of joining group:

Your license indicates you are certified as:

License #: State: Issue Date: Exp. Date:

NOTE: Mental Health Providers, please provide a copy of most current license.

Primary Specialty: Board Certified Yes No

Secondary Specialty: Board Certified Yes No

NOTE: If more than one location, please list locations on an additional sheet.

Physical Address:

City, State, Zip: *Effective Date:

Phone: Fax:

Mailing or Billing (please specify):

Service Name: Type 2 NPI #:

Street Name:

City, State, Zip: *Effective Date:

Phone: Fax:

*Make Payment Payable to:

*Federal Tax ID # *IRS Legal Entity Name:

NOTE: Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) must be reported exactly as recorded with the IRS. Please complete and return IRS form W9 with this questionnaire. Additionally, a copy of the letter or e-mail from the Enumerator verifying NPI assignment must be included with this form.

Table with 5 columns: Patient Name, Date of Service, Subscriber Number, CLAIM NUMBER (REQUIRED), Direction of Pay: PP = Pay Provider, PS = Pay Subscriber

Signature of person completing this form Date Phone No.