



Request to Establish or Revise a Facility Record

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

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

Facility Name: _____

Specialty (any limitations to practice, e.g., substance abuse only, MRI only): _____

What is the facility licensed as? _____

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

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

JCAHO Accreditation: Yes [] No []

*NPI (National Provider Identifier) #: _____ Medicare Provider Number: _____

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: _____

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. _____