MEDICAL PRACTICE MANAGEMENT SERVICES
ENROLLMENT FORM

PRACTICE TAX ID			PRACTICE NPI		
PRACTICE NAME					
PRACTICE ADDRESS					
PRACTICE CITY	STATE		ZIP CODE		COUNTRY
PRACTICE PHONE NUMBER *(MANDATORY)* ( )			FAX		
WEB SITE			EMAIL ADDRESS		

COMPLETE THE FOLLOWING SECTION FOR EACH PROVIDER. SPACE IS PROVIDED FOR 3 PROVIDERS, PLEASE PHOTOCOPY IF MORE SPACE IS REQUIRED.

PROVIDER LAST NAME AND TITLE	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME	DATE OF BIRTH
STATE LICENSE NUMBER *(Required)*		INDIVIDUAL NPI	CITY OF BIRTH	COUNTRY OF BIRTH
SOCIAL SECURITY NUMBER *(Required)*		CAQH ID		
PAYMENTS ARE SENT TO:				
UNDER GRADUATE SCHOOL	START DATE (MM/YYYY	END DATE (MM/YYYY)	DEGREE	
POST GRADUATE SCHOOL	START DATE (MM/YYYY	END DATE (MM/YYYY)	DEGREE	
BOARD CERTIFIED (Y) YES (N) NO	NAME OF CERTIFYING BOARD		YEAR OF CERTIFICATIO	NEXT RENEWAL DATE

MEDICARE GROUP NUMBER	MEDICARE INDIVIDUAL NUMBER	MEDICARE PAR? (Y) YES (N) NO	
MEDICAID GROUP NUMBER	MEDICAID INDIVIDUAL NUMBER	MEDICAID PAR? (Y) YES (N) NO	
BLUE SHIELD GROUP NUMBER	BLUE SHIELD INDIVIDUAL NUMBER	BLUE SHIELD PAR? (Y) YES (N) NO	IN NETWORK? (Y) YES (N) NO
GROUP NPI	INDIVIDUAL NPI		
NETWORK NAME	NETWORK GROUP NUMBER	NETWORK INDIVIDUAL NUMBER	
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