MEDICAL PRACTICE MANAGEMENT SERVICES
ENROLLMENT FORM

PRACTICE TAX ID		**PRACTICE NPI**	
PRACTICE NAME			
PRACTICE ADDRESS			
PRACTICE CITY	**STATE**	**ZIP CODE +4**	**COUNTY**
PRACTICE PHONE NUMBER *(MANDATORY)*		**FAX**	
WEB SITE		**EMAIL ADDRESS**	

COMPLETE THE FOLLOWING SECTION FOR EACH PROVIDER IN THE PRACTICE.

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

PLEASE LIST ALL CURRENT NETWORK AFFILIATIONS

NETWORK NAME	**NETWORK GROUP NUMBER**	**NETWORK INDIVIDUAL NUMBER**
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