MEDICAL PRACTICE MANAGEMENT SERVICES
ENROLLMENT FORM

COMPLETE THE FOLLOWING SECTION FOR THE LEGAL PRACTICE ENTITY:

PRACTICE TAX ID		TYPE II NPI		
LEGAL BUSINESS NAME				
LEGAL BUSINESS ADDRESS (WHERE CHECKS ARE TO BE MAILED)				
CITY	STATE	ZIP CODE +4	COUNTRY	COUNTY
PRACTICE PHONE NUMBER *(MANDATORY)*		FAX		
WEB SITE		EMAIL ADDRESS		

LIST ALL LOCATIONS WHERE SERVICES ARE PROVIDED: Use additional sheets if necessary

SERVICE LOCATION 1 ADDRESS				
CITY	STATE	ZIP CODE +4	Is this a facility?	COUNTY
OFFICE HOURS				
MONDAY:	TUESDAY:	WEDNESDAY:	THURSDAY:	FRIDAY:
SATURDAY:	SUNDAY:	DO YOU SHARE LOCATION?	Effective Date:	
SERVICE LOCATION 2 ADDRESS				
CITY	STATE	ZIP CODE +4	Is this a facility?	COUNTY
OFFICE HOURS				
MONDAY:	TUESDAY:	WEDNESDAY:	THURSDAY:	FRIDAY:
SATURDAY:	SUNDAY:	DO YOU SHARE LOCATION?	Effective Date:	

COMPLETE THE FOLLOWING SECTION FOR EACH PROVIDER:

PROVIDER LAST NAME AND TITLE	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME	DATE OF BIRTH
STATE LICENSE NUMBER	LICENSE ISSUE DATE	LICENSE EXPIRATION DATE	CITY OF BIRTH	COUNTRY OF BIRTH
SOCIAL SECURITY NUMBER	TYPE I NPI	CAQH ID	CAQH USERNAME	CAQH PASSWORD
UNDER GRADUATE SCHOOL	START DATE (MM/DD/YY)	END DATE (MM/DD/YY)	DEGREE	
POST GRADUATE SCHOOL	START DATE (MM/DD/YY)	END DATE (MM/DD/YY)	DEGREE	
BOARD CERTIFIED? (Y) YES (N) NO	NAME OF CERTIFYING BOARD		CERTIFICATION DATE	EXPIRATION DATE

COMPLETE THE FOLLOWING SECTION FOR INSURANCE COMPANY:

MEDICARE GROUP PTAN	MEDICARE INDIVIDUAL PTAN		
MEDICAID GROUP NUMBER	MEDICAID INDIVIDUAL NUMBER (LIST ALL)	IS THE PROVIDER A MEDICAID PROVIDER OR CHIP ONLY?	
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 AFFILIATED INSURANCE NETWORKS:

NETWORK NAME	NETWORK GROUP NUMBER	NETWORK INDIVIDUAL NUMBER
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