# MEDICAL PRACTICE MANAGEMENT SERVICES
# ENROLLMENT FORM

| SECTION A: 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 | | |
| AFTER HOURS PHONE NUMBER | | AFTER HOURS COVERAGE POLICY | | |
| WEB SITE | | EMAIL ADDRESS | | |
| **SECTION B: LIST ALL SERVICE LOCATIONS: Use additional sheets if necessary** | | | | |
| SERVICE LOCATION ADDRESS | | | | |
| CITY | STATE | ZIP CODE +4 | Is this a facility? | COUNTY |
| **SECTION C: 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 |
| PROVIDER'S EMAIL: | | | | |

Complete all sections to add a new billing provider and practice.
Complete Section B to add only a new practice location.
Complete only Section C to add a new provider to an exisiting group.