



Information Needed

Full Name of Business _____

Doctor Name _____

Phone Number _____

Fax Number _____

Email Address _____

Business Address(es)
(Physical and Pay to) _____

SS# or Employer ID # _____

Medicare Provider # _____

Group Medicare # _____

Blue Shield # _____

Group Blue Shield # _____

Medicaid # _____

Group Medicaid # _____

Railroad Medicare # _____

Group RR Medicare # _____

DMERC # _____

Other #'s (HMO/PPO) _____

NPI # _____

Group NPI # _____

Please attach a Medicare EOB or the Medicare approval letter (this will ensure correct information and expedite your payment)

A copy of your fee schedule and a list of facilities (with appropriate place-of-service) will also be needed