Paperless Doc

Provider Setup Form
800-583-9257

Pay to Name _____

Pay to Address _____

City _____ **State** _____ **Zip** _____

Contact _____ **Phone** _____

Fax _____ **E-Mail** _____

Tax ID/SSN _____ **Specialty** _____

Provider Name _____

NPI _____ **Group? (YES / NO)**

For Govt. carriers (Medicare, Medicaid, BC/BS, Champus, Railroad Medicare)

Type	State/Region	Group ID	Provider ID