

INSTRUCTIONS FOR COMPLETING THE PROVIDER APPLICATION

(ALL INFORMATION MUST BE PRINTED LEGIBLY OR TYPED)

CONTRACT

- PAGE 1: “The Provider” – means the individual provider **or** the organization/group.
- **Individual Provider** – print or type provider name on the first line, leave next line blank
 - **Organization or Group** – print or type organization or group name on the first line and the name of the person authorized to sign for the organization or group on the next line.
- I. **PLEASE READ CAREFULLY AND NOTE :**
- The reimbursement rates
 - The Program is payor of **last** resort.
 - Acceptance as **payment in full** the amount reimbursed by the Program and/or the patient’s health insurance, if applicable, **and not** to seek additional payment from the patient except in the case of commercial insurance co-insurance amounts. Billing the patient for account balances except as described is a **violation** of this agreement.
- PAGE 2: II. **PLEASE READ CAREFULLY AND NOTE:**
- Termination requires 30 days notice in writing and notification of patients **prior** to rendering additional services of your withdrawal from the Program. This provides patients the opportunity to transfer to a participating provider.
 - Please obtain appropriate signature

DEMOGRAPHIC INFORMATION

- PAGE 1: **INDIVIDUAL PRACTICE** – Any individual M.D. or individual M.D. within a group practice when the group is not contracting with the Program.
- GROUP PRACTICE/ORGANIZATION** – Complete only when all physicians of a group are applying to participate. **Please provide a list of all individuals and ALL of their office locations.**
- BILLING ADDRESS – PLEASE ATTACH A COPY OF THE W-9**
- **Tax ID number** – This is the ID number used. If the tax ID is used by another organization (e.g., hospital, corporate pharmacy, etc.) a suffix must be added to the Tax ID number. This suffix identifies your organization separately for payment and **must** appear on all claims. The billing address must match exactly that which appears in Box 33 of the CMS 1500. **Any** changes must be reported **immediately** to the central office in order to prevent a delay in payment. **Please identify the Tax ID# as SSN or EIN.**
 - **Please provide a BLANK copy of a CMS 1500 with your billing name and address in Box 33 (OBTAIN FROM YOUR BILLING OFFICE).**
 - **Contact Person** – Please provide the name and telephone number of the person to contact in case of problems. This should be the office manager or billing supervisor.
 - **Medical Office** – Please provide a list of all offices locations and their respective contact persons. This information is helpful to our patients and providers.
- PAGE 2: **NPI NUMBER** – Please provide your National Provider Identifier number on the appropriate line.
- LICENSE NUMBERS** – Please provide copies of all applicable licenses. Your office will be asked to update this information periodically. If physicians, please attach a copy of each individual’s current medical license.

ATTACHMENTS:

- PAGE 1: Billing information for all providers except pharmacies
- PAGE 2: Billing information for pharmacies only