D&D CLAIMS ELECTRONIC ENROLLMENT

Practice Tax-ID:_____

PHYSICAL LOCATION

Billing Name:_____

Billing Address:_____

Billing City:_____ State:____ Zip:(9)_____

Telephone:_____ Fax:_____

Practice Name(DBA):_____

Provider Last Name:_____ Provider Title:_____

Provider MI:_____ Provider DOB:_____

Provider First Name:_____ Provider Specialty:_____

SS#:(if same as tax ID#):_____ NPI#_____

License#:_____ CLIA#:_____ GROUP NPI#:_____

Medicare ID#:_____ Participating (YorN):____

Blue Shield ID#:_____ Participating (YorN):____

Medicaid ID#:_____ Participating (YorN):____

RR Medicare ID#:_____ Participating (YorN):____

Medicare Group#:_____B/S Group#:_____Medicaid Group#:_____

OTHER CARRIER NAME	PROVIDER'S NPI ID#	PAR (YorN)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Make checks payable to Group or Individual Physician (P or G):_____
Specific Agreements may be required by certain carriers (enclosed).
One enrollment form required per Physician.