



Medicare Enrollment Form- Group

If billing under a tax id instead of your social security number, please complete the following:

Official Practice Name (as registered with IRS):

Are you the only owner?

State where incorporated:

Date of Incorporation:

Solo or Group Practice:

Tax ID:

Group NPI (if available):

Names of other shareholders:

Number of Locations where you plan to see patients:

Number of Providers to be credentialed:

Primary Specialty of Provider(s):

NPI Login Information for Group and Individual NPI #s: (This is needed to complete the Medicare application and to ensure that the Medicare crosswalk completes correctly)

(If you do not have the login info, Provider must call NPI Enumerator at 1-800-465-3203 and reset password)



Mailing Address (For Correspondence):

Office Fax Number:

Office Phone Number:

Office Email (If Available):

Website (if available):

Billing Address (If Different):

Do you plan to use a billing agency?

Please furnish the name and contact info for the billing company:

Office Contact Name:

Contact Number:

Contact Email:

Contact Method: Phone or Email



Office Locations:

Do you plan to see patients in their homes? Yes No

Primary Office

Secondary Office

Other Offices: (Attach Separate Page if Necessary)

Required Documents:	
Group NPI Confirmation Letter (If Available)	
IRS form CP-575	
Voided Check or Bank Letter	
Business License	

SECTION 2: IDENTIFYING INFORMATION

A. Personal Information: Your name, date of birth, and social security number must coincide with the information on your social security record.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Other Name, First	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Type of Other Name

Former or Maiden Name Professional Name Other (*Describe*): _____

Date of Birth (<i>mm/dd/yyyy</i>)	State of Birth	Country of Birth
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Gender

Male Female

Social Security Number

Medical or other Professional School (*Training Institution, if non-MD*)

Year of Graduation (*yyyy*)

DEA Number (*if applicable*)

License Information

License Not Applicable

License Number	State Where Issued
Effective Date (<i>mm/dd/yyyy</i>)	Expiration/Renewal Date (<i>mm/dd/yyyy</i>)

Certification Information

Certification Not Applicable

Certification Number	State Where Issued
Effective Date (<i>mm/dd/yyyy</i>)	Expiration/Renewal Date (<i>mm/dd/yyyy</i>)

New Patient Status Information

Do you accept new Medicare patients? Yes No

B. Correspondence Address

Provide contact information for the person shown in Section 2A above. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 (<i>Street Name and Number</i>)		
Mailing Address Line 2 (<i>Suite, Room, etc.</i>)		

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (<i>if applicable</i>)	E-mail Address (<i>if applicable</i>)