Provider Information Sheet

Infinedi™ ELECTRONIC DATA INTERCHANGE

_____ New Enrollment Complete sections 1,2, & 3
_____ Delete a Provider Complete section 1 only
_____ Add a Provider Complete sections 1,2, & 3

You must complete this form accurately and completely for each provider in your group. Please make copies as needed.

Section 1

Do you want your account setup as a Group / Practice or Individual Provider? GROUP/ INDIVIDUAL

Group / Practice Name: _____

Providers Name including credentials: _____

Provider Specialty: _____ SSN: _____

Address: _____

City: _____ State: _____ Nine Digit Zip: _____

Phone : _____ Fax : _____

Contact: _____ Email: _____

Section 2

If you do not participate in one of the following, please print N/A in the space provided or "pending" if provider #'s are pending:

Medicaid (Individual #)_____ (Group #)_____

BC/BS (Individual #) _____ (Group #)_____

Medicare (Individual #)_____ (Group #)_____

Railroad Medicare (Individual #)_____ (Group #)_____

Tricare (Individual #)_____ (Group #) _____

DMERC # _____ State Medical License # _____

Type I NPI (individual) _____ Type II NPI (Organization) _____

Taxonomy Code_____ Facility Taxonomy Code_____

CLIA # _____

Please attach a list of any additional carriers and provider number you may file claims to

Section 3

How do you want to receive payment for claims? You may choose only one option:

Group Tax-ID_____(OR) Individual Tax-ID_____(OR) Provider Social_____

Name_____

Address_____

City_____State_____Nine Digit Zip_____

Internal use: Account #_____-_____Ticket #_____

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