Date: _____

Enrollment Form

PROVIDER INFORMATION

Practice Name: _____

DBA (Same ☐) _____

Practice Address: _____
Street City State Zip

Practice Tax ID #: _____

TELEPHONE NUMBERS AND CONTACTS

Practice: _____ _____ _____ _____
NAME TELEPHONE NUMBER FAX NUMBER E-MAIL

Office Manager _____ _____ _____ _____
NAME TELEPHONE NUMBER FAX NUMBER E-MAIL

Billing Manager: _____ _____ _____ _____
NAME TELEPHONE NUMBER FAX NUMBER E-MAIL

Technical Support Co.: _____ _____ _____ _____
NAME TELEPHONE NUMBER FAX NUMBER E-MAIL

Technical Contact: _____ _____ _____ _____
NAME TELEPHONE NUMBER FAX NUMBER E-MAIL

Practice Management Software Name (PMS): _____

Box 33 (Physician's, Supplier's Billing Name, Address, Zip Code & Phone #) should read as follow:

_____

_____

_____

_____

CARRIERS REQUIRING UNIQUE EDI CODE NUMBERS TO BE BILLED

Medicare	**Yes**	☐	**No**	☐
Railroad Medicare	**Yes**	☐	**No**	☐
Nevada Medicaid	**Yes**	☐	**No**	☐
Blue Cross/Blue Shield	**Yes**	☐	**No**	☐
Champus	**Yes**	☐	**No**	☐
Encounters	**Yes**	☐	**No**	☐
Nevadacare	**Yes**	☐	**No**	☐

SPECIAL NOTE: All claims submitted for any carriers identified above will be sent via paper until HCR has received your unique EDI code. _____
Initials