UnitedProviders

1 Trans Am Plaza Dr., Ste 16 Oakbrook Terrace IL 60181 Ph: 630.827.2500 Fax: 630.242.8450

Provider Information Form

Physician Information

First Name: *	Middle Initial:	Last Name: *	Suffix:
Mailing Address Line 1(Street Name and Number):			
Mailing Address Line 2:			
City:	County:	State:	Zip:
Telephone #: *	Fax #:	Email Address: *	
Date of Birth: *	SSN: *	CLIA #:	UPIN #:

* This information is needed for Medicare Solo-practitioner enrollment:

State of Birth: *	Country of Birth: *	Year of Graduation:*	Medical School: *
NPI Type 1 (Individual):	NPI Registry – Username:		Password:
DEA #:	State of Illinois Physician License # & Effective Date:		

* Driver's license information is required for enrolling into the MEDI system at IDPA.
Please provide the following information exactly as it appears on your driver's license.

Driver's License #:*	Weight:* lbs	Height:* ft in

Corporate Information

Provider Legal Business Name: *	Doing Business As (if different):

Address of Service Location - Clinic or Practice Location (Street Name and Number): *

City:*	County:*	State:*	Zip:*
Physician's Specialty(s): *	Category of Service:	Tax ID (FEIN):	Corporate Number:
NPI Type 2 (EntityIndividual):	NPI Registry – Username:		Password:

☐ Corporation ☐ Partnership ☐ Other :

Date Started:	Incorporation Date (if applicable):	State of Incorporation:

Power of Attorney

Name:

Address:

City:	County:	State:	Zip:

General Questions

1. Where are Patient Medical Records stored?

2. Have you or your practice ever had any adverse legal action against you?
   ☐ Yes ☐ No
3. Do you already have a previous billing agency?
   ☐ Yes ☐ No
4. What are the hospitals to which you admit patients?
   1. Name, Address:

   2. Name, Address:

5. Do you need a superbill designed?
   ☐ Yes ☐ No
6. Do you have a procedure pricelist?
   ☐ Yes ☐ No
7. Do you have Highspeed Internet available at your service location?
   ☐ Yes ☐ No

Attachments

Please check all the attachments provided (copy of each):

- ☐ Driver's License
- ☐ State Professional License
- ☐ State Controlled Substance License
- ☐ CLIA License
- ☐ Federal DEA License
- ☐ M.D. Degree Certificate
- ☐ Residency Certificate
- ☐ Voided Original Bank Check / Bank Letter with Acc. No. and ABA Routing No. for EFT setup
- ☐ Existing Superbill
- ☐ Medicare Provider Information Sheet
- ☐ IDPA Provider Information Sheet
- ☐ IRS Letter 147C – (FEIN) Tax ID Letter
- ☐ Completed W-9 form for IRS
- ☐ Ownership Information
- ☐ Malpractice Insurance
- ☐ Professional Liability Insurance
- ☐ U.S. Citizenship and Immigration Services Approval Letter

Insurance Information

Medicare Part-A ID:	Group #: (if applicable)	☐ check here if required
Medicare Part-B ID:	Group #: (if applicable)	☐ check here if required
PTAN #:	Medical License:	☐ check here if required
Blue Cross Provider #:		☐ check here if required
Medicaid ID #:	Medicaid Payee #:	☐ check here if required

Other Insurance IDs:

1.	2.
3.	4.

Hospital Information

Hospital Name:	Address:
1.	
2.	

Bank Deposit Information

This section is required for Electronic Fund Transfer.

Depository (Bank) Name:

Depository Address (Street Name and Number):

City:	County:	State:	Zip:

Administrative Contact Person (e.g. Bank Manager):	Depository Phone #:

Account Holder's Name:

Depository Routing Transit #:

Depository Account #:

Type of Account: *(Check One)*

☐ Checking Account ☐ Savings Account

Additional Information

Council for Affordable Quality Health Care (CAQH) ID #:	CAQH login id:	CAQH password:

PECOS username:	PECOS password:
Electronic Data Interchange (EDI) #(s): Availity Submitter ID:	WPS Submitter ID:
Noridian Submitter ID:	Trailblazer Submitter ID:
Emdeon Submitter ID:	Zirmed Submitter ID:

United Providers shall keep all personal and corporate information strictly confidential and under no circumstances will disclose this information without consent of the owner and/or will only furnish the required information to appropriate authorities for credentialing and contracting purposes for the Provider.

Please email scanned copies of all the available documents requested on page 2 at: credentialing@unitedproviders.net

Signature of Provider: _____ Date: _____

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