CEN-TEX MEDICAL CLAIMS - PROVIDER ENROLLMENT FORM

Federal Tax ID #: ___________________________ NPI # ______________________________(Type 2 if group)

Practice Name: ____

Phone#(s): ____ Fax #: __________________________________

Email: ____Contact Person / Title: ____________________________

Billing Address: ____

City: ___________________________ State: ___________ Zip Code(+4): _________- _______

Service Address (if different than above): ____

City: ___________________________ State: __________ Zip Code (+4):________-________

Group Medicare Provider #: ________________________(if applicable)

Group Medicaid Provider #: ________________________(if app.) Which Medicaid Plans?__________________

FOR ALL PROVIDERS – complete for each individual provider if in group

Last Name:___________________________ First Name:________________ MI:______ Credentials:__________

SSN: ____________________________ DOB:_________________ Cell Phone (optional)__________________

License Number(s): #__________________State:_______Orig.IssueDate:__________ CurrentExp.Date_______

#__________________State:_______Orig.IssueDate:__________ CurrentExp.Date_______

NPI Number-Individual (type 1)____

Specialty(s):____

Are you in the CAQH database? _______________ If so, your CAQH provider ID#:________________________

Medicare Participating?:_______________________ Individual Medicare ID: ______________________________

Yes = accepts assignment; No= does not

Medicaid Participating?:_______________________ Individual Medicaid ID: ______________________________

Which Medicaid plans do you participate with?____

List of Insurance Companies you are In-Network with: ____

____

Practice Limitations?____

____

Specific Practice Need or Concerns?____

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