

REQUEST FOR MEDICAID PARTICIPATION AS A GROUP MEMBER

1. Individual Provider Name: _____

2. Individual Provider Number: _____
(You must enroll to participate) 10-digit NPI (Required)

8-digit Medicaid ID (Required)

3. Name of Group: _____

4. Group's Provider Number: _____
10-digit NPI (Required)

8-digit Medicaid ID (Required)

5. List the Service address(es) where you will work as a group member. Do not list private practice service addresses.

(a) _____ _____ _____	(c) _____ _____ _____
(b) _____ _____ _____	(d) _____ _____ _____

6. List the first Date of Service that services were rendered to Medicaid patients as part of the Group.

Month Day Year

I agree to participate in the Medicaid Program as a member of the above listed group. I realize that I continue to remain personally responsible for all claims billed to Medicaid using both group Medicaid identification number and my individual provider number. I may have my name withdrawn from the above listed group upon written request to the above address.

Name (please print): _____
(First) (Full Middle Name) (Last)

Signature: _____

Date: _____