

Practice Data: <input type="checkbox"/> Phys Practice <input type="checkbox"/> ASC <input type="checkbox"/> Billing Svc				
Practice Specialty				
Tax ID			<input type="checkbox"/> EIN or <input type="checkbox"/> SSN	
Practice Name				
Physical Location				
City		State	Zip	
County				
Practice currently transmitting electronically?				
Providers who are currently transmitting electronically must give the start date that PracticeAdmin can begin to submit on their behalf. This will cause existing connections to be deactivated for some payers. / /				

Contact Data: (This person will enroll users online & must be eligible for "manager level" access.)				
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.				
Contact Name				
<input type="checkbox"/> Bill to Group/Practice Address <input type="checkbox"/> Invoice this Address				
Mailing Address				
City		State	Zip	
Email				
Phone - - X				
Fax - -				

I have the authority to, and hereby do, enter into this Agreement on behalf of my Group/Practice, including on behalf of all physicians or other providers affiliated with this Group/Practice. I authorize PracticeAdmin LLC (PA) to enroll the practice for the EDI transactions included below. This Agreement includes and incorporates the terms and conditions of the PA Practice Web Site Subscriber Agreement and Web Site policies that appear on the PA web site, which I have reviewed. I agree that my Group/Practice is bound by the terms and conditions of this Agreement, including but not limited to Section 7 of the PA Practice Web Site Subscriber Agreement (limitation of liability).

I have been presented with a fee schedule listing the fees and charges associated with PA. I understand that this Group/Practice is obligated to pay for such fees and charges incurred while using PA, and certain additional services offered through PA that may be subject to additional fees charged by PA or third parties. Fees and charges are subject to change, and such changes are effective 30 days after notification is given by PA.

I understand that staff, physicians, and other providers enrolled under this Agreement may be able to transmit patient medical information to payers and to other health care professionals and to receive such information from others. I agree that the Group/Practice's administrator, or any affiliated physician or other provider (if any), has authority to enroll staff, designate the appropriate level of access for each individual, and to oversee all arrangements necessary to ensure that use of the Services is in compliance with applicable state and federal laws and this Agreement.

<b>Print Authorized Agent Name</b>	
<b>Authorized Agent Signature</b>	
<b>Date</b>	

Complete this form and fax to: 866-433-9399

Mail the original to:  
PracticeAdmin LLC  
135 Technology Parkway  
Norcross, GA 30092

Email [enrollments@practiceadmin.com](mailto:enrollments@practiceadmin.com) or  
Call 888-294-9255 for assistance.

I authorize PracticeAdmin LLC to transmit and receive to/from the following payers electronically on my behalf (NOTE: ERAs are not available from all payers):

Claims	ERAs	Payer
<input type="checkbox"/>	<input type="checkbox"/>	None (No Electronic Claims)
<input type="checkbox"/>	<input type="checkbox"/>	Commercial
EDI enrollments for the following payers cannot be initiated by PracticeAdmin LLC without provider IDs		
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	BCBS
<input type="checkbox"/>	<input type="checkbox"/>	Tricare (must give rendering IDs)
<input type="checkbox"/>	<input type="checkbox"/>	RR Medicare

Please supply the following information so that we may initiate the appropriate enrollment forms.  
(Note: If you are entering the following data in PA Setup, you do not need to complete this page. However, PracticeAdmin cannot process enrollment requests without payer required data. Illegible, incorrect, or omitted information may cause a delay in the enrollment process.)

Group Identification Numbers			
Payer Name	Group Number	Payer Name	Group Number
Medicare		BCBS	
Medicaid		RR Medicare	
NPI			
Other	(specify payer)		
Other	(specify payer)		

Provider Identification Numbers			
Provider Name:			Degree/Title:
Specialty:			State License:
Payer Name	Provider Number	Payer Name	Provider Number
Medicare		BCBS	
Medicaid		RR Medicare	
TriCare		NPI	
Other	(specify payer)		
Other	(specify payer)		

Provider Identification Numbers			
Provider Name:			Degree/Title:
Specialty:			State License:
Payer Name	Provider Number	Payer Name	Provider Number
Medicare		BCBS	
Medicaid		RR Medicare	
TriCare		NPI	
Other	(specify payer)		
Other	(specify payer)		

Provider Identification Numbers			
Provider Name:			Degree/Title:
Specialty:			State License:
Payer Name	Provider Number	Payer Name	Provider Number
Medicare		BCBS	
Medicaid		RR Medicare	
TriCare		NPI	
Other	(specify payer)		
Other	(specify payer)		

Provider Identification Numbers			
Provider Name:			Degree/Title:
Specialty:			State License:
Payer Name	Provider Number	Payer Name	Provider Number
Medicare		BCBS	
Medicaid		RR Medicare	
TriCare		NPI	
Other	(specify payer)		
Other	(specify payer)		