**STATE OF RHODE ISLAND**
**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**
**ADDING MEMBERS TO A NEW OR EXISTING GROUP PROVIDER APPLICATION FORM**

| | | |
|---|---|---|
| **Group Name:** | | **Group National Provider Identifier (NPI) Number:** |
| **Service Location Address:** | | **Group Taxonomy (ies):** |
| | | **Group Tax Identification Number:** |
| **Pay To Address:** | | |
| **Mail To Address:** | | |
| | | |
| **Phone Number:** | | **DXC Use Only** |
| **Fax Number:** | | **Census Track:** / **County Code:** |
| **Group Email address:** | | **Town Code:** / **Location Code:** |

**NEW GROUP MEMBERS:**

**I understand fully the standard of participation as stated in the State of Rhode Island, Executive Office of Health and Human Services, Provider Agreement Form (enclosed in enrollment packet) and will participate in the Rhode Island Medicaid Program in accordance with these standards.**

| PROVIDER NAME | SOCIAL SECURITY NUMBER ** | EFFECTIVE DATE w/GROUP | NATIONAL PROVIDER IDENTIFIER | TAXONOMY(S) | LICENSE # | PROVIDER TYPE & SPECIALTY | SIGNATURE | DATE |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**Signature of Provider, Senior Partner, or Chief Corporate Officer of Group** **Title**

*****This is a CMS Requirement***

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED*****
**PLEASE LIST ADDITIONAL GROUP PROVIDERS ON NEXT PAGE**