

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
INDIVIDUAL PROVIDER ENROLLMENT FORM

Shaded Area for HP Enterprise Services use only

Provider Number

Link ID

1. Provider Name _____
2. Business Name (if applicable) _____
3. Business Type Sole Other
(Attach supporting documentation)
4. Owner/Administrator, Managing Employee or Officer of Corporation Name **O**____ **A**____

5. Social Security Number _____ or FEIN _____
6. Service Location Address _____ City _____ State _____ Zip _____
Telephone (____) _____ Fax Number _____
7. Pay to Address _____ City _____ State _____ Zip _____
8. Mail to Address _____ City _____ State _____ Zip _____
Telephone (____) _____ Fax Number _____
9. Billing Service Address _____ City _____ State _____ Zip _____
Telephone (____) _____ Fax Number _____
10. Additional Practice Locations:
Street _____ City _____ State _____ Zip _____
Street _____ City _____ State _____ Zip _____
Street _____ City _____ State _____ Zip _____
11. Office Email Address _____ Contact Person _____

Name Type _____
Census Tract _____
Cnty Code _____
Town Code _____
Location _____

12. Medical License, License Chemical Dependency or Certification Number

13. Are you currently or have you ever been a provider under another medical specialty with Medicaid? YES NO

Dates: (Active and Inactive) _____

Status: _____

If Yes: What is your Rhode Island Medicaid ID Number/s _____

14. Is this application due to a merger, buy out or take over?

YES NO

15. List any outstanding balance owed to Executive Office of Health and Human Services Medicaid program by previous provider? _____

16. List your Medical Specialty _____ (see attached document)

17. National Provider Identifier (NPI) Number/s _____

18. Taxonomy Number/s _____

19. Medicare Number, if applicable (please also send CMS letter) _____

20. CLIA Number (Clinical Laboratory and Hospitals) _____

21. Number of Licensed Beds _____

Number of Swing Beds _____

22. Electronic Biller YES NO

23. Fiscal Year End Date _____

24. Are you a Full or Part-time Salaried Employee of a Hospital or Institution?

YES NO

If Yes, Name of Facility: _____

25. Enrollment effective date or date first served RI Medicaid client.

_____ (Effective date is mandatory)

