

Medicaid EHR Incentive Payment

New Managed Care Group Enrollment Form

Please note that completing this form is not necessary if you currently have a Rhode Island Medical Assistance number.

Group Name				
Group Numbers	Group NPI ID		Group TAX ID	
Office Address	Street		Suite/Room	
	City	State	Zip	
	Contact Name	Title	Phone	
Pay To: Address	Street		Suite/Room	
	City	State	Zip	
	Contact Name	Title	Phone	
Mail To: Address	Street		Suite/Room	
	City	State	Zip	
	Contact Name	Title	Phone	
Group Member's Information*	Last Name	First Name	Middle Initial	Title
	NPI	Rite Share ID**	Rhody Health ID**	
	Group Member's Signature			
	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Sign			<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date

Groups, establishing a practice, please include:

- W-9, signed
- Provider Agreement, signed
- Addendum I, signed
- Disclosure, signed
- Electronic Funds Transfer (EFT) form
- A copy of the NPI letter from CMS that contains the group's NPI and Taxonomy number

* Please enclose a copy of each member's license and NPI letter from CMS

** Please leave blank if not applicable