

Rite Share Co-Insurance and Deductible Only New Group Enrollment Form

Please note that completing this form is not necessary if you are already
an enrolled provider with RI Medicaid.

Group Name			
Group Tax ID Number	Group		
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
Group Member's Signature:	_____			Date
	Sign			
Group Member's Information*	Last Name	First Name	Middle Initial	Title
Group Member's Signature:**	_____			Date
	Sign			

Groups, establishing a practice, please include:

- W-9, signed
- Provider Agreement, signed
- Addendum I, signed
- Disclosure
- Exclusion Letter
- Electronic Funds Transfer (EFT) form with back up (ex. Voided check or bank letter)
- 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

** Only one signature is permitted and must be consistent on all enrollment documents