DMHSAS Only Provider Information for OHCA Payment Purposes

PROVIDER: Please fill out this form completely and have authorized representative sign. Attach a copy of either a voided check OR a letter from your Financial Institution confirming your bank account number. For National Provider Identifier (NPI) go to https://nppes.cms.hhs.gov/NPPES/Welcome.do

Name of Facility or Organi	ization							
Name of Facility or Organization Doing Business As (DBA) Type Of Organization:				NPI (National Provider IdentIfier) NPI Effective date				
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∐Non - Profit	∐ Partnership)	☐ Public Service	ce Corporation		iip		
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Service Location Address (PO Box is not acceptable):				Mail To Address (If dlfferent from Service location)				
Number and Street (PO Box is not acceptable)				Number and Street or PO Box				
Suite / Bldg #				Suite / Bldg #				
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a)	Transit routing Number									
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	Account Number									
	Financial Institution Account Type									
	A voided check or letter from the Financial Institution must be attached to this application.									
Q:	Signature of Organization's Authorized Representative Date									
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