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

FACILITY INFORMATION

Section 1

____
Name of Facility or Organization

____ ____________________ ________________
Doing Business As (DBA) NPI (*National Provider Identifier*) NPI Effective date

Type Of Organization:

- ☐ For Profit Corporation ☐ Estate/Trust ☐ Government Owned ☐ Limited Liability Company
- ☐ Non - Profit ☐ Partnership ☐ Public Service Corporation ☐ Sole Proprietorship

ADDRESSES

Section 2

Service Location Address *(PO Box is not acceptable)*:

____
Number and Street (*PO Box is not acceptable*)

____
Suite / Bldg #

____________________________________-_____
City State Zip 4 digit zip

(____)____________________________________
Phone Number Fax Number

Mail To Address *(If different from Service location)*

____
Number and Street or PO Box

____
Suite / Bldg #

____________________________________-_____
City State Zip 4 digit zip

(____)____________________________________
Phone Number Fax Number

Pay To Address (*if different from Service Location)*

____
Number and Street or PO Box

____
Suite / Bldg #

____________________________________-_____
City State Zip 4 digit zip

(____)____________________________________
Phone Number Fax Number

CONTACT INFORMATION

Section 3

Provider Enrollment Contact

First Name (Enrollment Contact) ____ Last Name ____ (____) Phone ____ ext ____ (____) Fax ____

Email ____

Clinical Services Contact (If dIfferent from Enrollment Contact)

First Name (Clinical Services Contact) ____ Last Name ____ (____) Phone ____ ext ____ (____) Fax ____

Email ____

Electronic Payment Contact (If dIfferent from Enrollment Contact)

First Name (Electronic Payment Contact) ____ Last Name ____ (____) Phone ____ ext ____ (____) Fax ____

Email ____

PAYMENT AND TAX REPORTING

Section 4

Tax ID ____

IRS Legal Name ____
(***Must match with IRS Form SS4 or IRS Letter 147C.)***

Transit routing Number ____

Account Number ____

Financial Institution ____ Account Type ☐ Checking ☐ Savings

A voided check or letter from the Financial Institution must be attached to this application.

____
Signature of Organization's Authorized Representative

____
Date

____
Print Authorized Representative's Name

____
Authorized Representative's Title