PriorityHealth

Provider Supplemental Enrollment Form

Personal information

Name (Last, First, Middle) _____ Degree/Professional title _____

Other names you may have used (Maiden, a.k.a., etc.) _____ Gender: Male ☐ Female ☐

Date of birth (month/day/year) _____ Medicare # _____

Individual NPI _____ State License # _____

Primary office practice information

Type of Practice:

Corporation ☐ Partnership ☐ Solo ☐ Institution ☐

Hospital Based ☐ Hospital Employed ☐ Rural/Federal Qualified Health Clinic ☐

Group practice name as it appears on SS4 or W-9 Form _____

Federal tax ID# _____ Group NPI _____

Address _____ Suite _____ City _____ State _____ County _____ Zip _____

Telephone number (_____)_____ Fax number (_____)_____

Email address _____ Internet access: Yes ☐ No ☐

Office Manager _____ Telephone number (_____)_____ Fax number (_____)_____

Billing address where payments are to be sent _____ City _____ State _____ Zip _____

Claims payable to _____

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List physicians and midlevels practicing at this location: Specialty:

_____

_____

_____

_____

Additional notes or comments:

_____

_____

_____

West and North region practices

Fax completed form to:
Attn: Contracting – 616.975.8851

Mail completed form to:
Priority Health, Contracting - MS2310
1239 East Beltline NE
Grand Rapids, MI 49525

East region practices

Fax completed form to:
Attn: Contracting – 248.324.2984

Mail completed from to:
Priority Health, Contracting - FH11
27777 Franklin Road, Suite 1300
Southfield, MI 48034-2337

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