

ADD PROVIDER FORM

(For Existing Users Only)

Current Office Ally Username:			
*If you do no	t have a current username, please	complete our enrollment fo	rm.
Contact Name:	Contact Phone Number:		
SEPARATE USERNAME REQUEST			
Is this provider part of a billing service If yes, List Billing Service:	Yes No		
Is a separate username needed? Yes	No Preferred usern	ame: *Office Ally cannot	guarantee that this username will be available.
If yes, settings on new username will be id	dentical to current username	unless specified here	:
	Contact Phone:		
Contact Email:			
	· •	•	ental processing fee of \$19.95/month per charged separately for each active username
TROVIDER INFORMATION			
Please fill out ALL information requested any manner that is easier for you (i.e, scre	•		You may also provide this information in
Solo Provider Name or Group Name:			
Address:			
City:	State:		Zip:
Tax ID or EIN #:	CLIA#:		
Individual/Rendering Provider NPI:		CMS 1500 = Box 24J	ADA = Box 54
Corporate/Billing/Group NPI:		CMS $1500 = Box 33A$	UB04 = Box 56 ADA = Box 49
Do you want Office Ally to add these NPI num	nbers to your claims?	☐ Yes ☐ No	

PAYER INFORMATION

A few of our payers require pre-enrollment that MUST be completed before sending claims electronically. To see a list of payers, go to www.officeally.com then click on "Payerlists/forms." Professional payers are listed in the CMS 1500 Payerlist, Institutional payers in the UB 04 Payerlist and Dental payers in the Dental/ADA Payerlist. All payers that require pre-enrollment are indicated by asterisks.