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**