



## Initial System Setup Information – 1 to 5 Users

**Company/Group Information – This information will print in Box 33 of a CMS 1500 claim form**

Company Name (Physician's Name or Group Name)

Mailing Address

City

State

Zip

Phone Number

Fax Number

Group Provider

Sole Provider

Group NPI Number

**Individual Provider Information – This information will print in Box 24J of a CMS 1500 claim form**

DR #

Last, First Name

Address

City

State

Zip

Phone Number

Cell Phone

Email Address

Professional License Type (e.g. MD, DO, PA...)

State License

Social Security Number

Tax ID Number

UPIN Number

NPI Number

Specialty

Taxonomy Code

Medicare PTAN

Medi-Cal Number

Please check the appropriate boxes below for the above provider  
 Participating Agreement    Accept Assignment    Signature on File