



**SITE ID: 337G**

**\*\*Required\*\***

**MEDICAL OFFICE PROVIDER ENROLLMENT FORM**

Please complete and return via email to [enrollassist@trizetto.com](mailto:enrollassist@trizetto.com)  
 If you are unable to email this form, please fax it to 314-802-6913.

**Please note the turnaround time for approval is 10 Business Days, you will be notified by Email or Fax, if you have a preference please indicate on the form.**

Contact Name:	Phone:
Email:	Fax:

**The information provided on this form MUST match what is on file with the payers.**

Group Information (if applicable)	Provider Information
Group Name:	First Name:
	MI:
DBA (if applicable):	Last Name:
	Title:
Group NPI:	Individual NPI:
Tax ID:	Specialty:

Service Location Address	Pay To Address (if different)
Street Address:	Street Address:
City, State, Zip +4:	City, State, Zip +4:

\*\*\*Indicate below the Individual and/or the Group Provider numbers, legacy ID's or PTANS issued by the payers. \*\*\*  
 Although these IDs may not be used on the claims, they are often required for EDI enrollment.

Insurance Company	Payer ID	Group Provider Number	Individual Provider Number
Intercommunity Health Net	INCHN		

## **Note to My Clients Plus Users:**

Once you have confirmed with the Insurance Payer your Billing NPI/ Provider Number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with “My Clients Plus” on top**
- **Provider/Practice Name as pre-enrolled with the Insurance Payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including state if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payer”.**
- **Provider email address where you can be notified of setup completion.**
- **For EDISS or Noridian Pre-Enrollments Please Also Include:  
Providers Submitter Number**

**REVISED 9/29/16**