NET HEALTHCLAIM SERVICES
PROVIDER IDENTIFICATION/CHANGE SHEET

(Please type or print clearly)

Provider Name: ____

NHS ClientID________
For internal use only

Clinic/Group Name_____________________________________

Address:____

City/St/Zip:____

Phone:______________________Fax______________________

Email:____

Address where checks are to be sent: (if different from above)
Address:____

City/St/Zip:____

Contact Name:____

Provider Specialty:_____________________________________

Software used:____

Provider Licensing information (if multiple States use additional sheet)

State of Business: __________________________

Taxonomy code:__________________________

TAX ID/EIN_____________________________

State License number:_______________________

NPI Ind #:_______________________ Grp#___________________________

CLIA#:____________________________

UPIN:_________________

Medicare Ind#:_______________________Grp#__________________________

Medicaid Ind#:_______________________Grp#:__________________________

BC/BS Ind#: ________________________ Grp#____________________________

Champus/Tricare: (SS#)___________________________

Railroad Medicare Ind#_______________________Grp#:_______________________

Other#:____

Please compete and email to ____

Attn: Applications Dept
www.applications@nethealthclaimservices.com