



# RENDERING PROVIDER FORM

## Request Type

Submit Date   New  Update  License Reporting Unit Effective Date  Terminate  Name Change

## General Information

Last Name:

First Name:

Middle Initial:  Sex: M F Ethnicity

DMH/NGA Staff Code

FFS Ind Prov No.

SSN (Last 4 only)

Language Code

Select DMH Classcode:

DMH  
Prov name:

DHS  
Prov name:

Non-Governmental Agency (DMH Contracted)  
L.E. #:

L.E. Name:

FFS Individual  FFS Group  FFS Org

Tax Payer ID (FFS only)

## Contact & Assigned Location Information

Contact name:  Contact Email:

Contact phone no: (  )  Contact Fax No: (  )

- Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)
- Delete this rendering provider in the service location indicated below.  Delete this rendering provider in ALL service locations within the legal entity indicated above.

DMH/NGA Prov No./Rept Unit  FFS Group/Org Prov No.   
(Please enter the provider no. associated to the above taxpayer ID)

Effective Date  Termination Date  Locum Tenum  Intern

Name of Organization:  Service Area  MHSA

Address:  City:  Zip:

## Taxonomy and License Information (Required if request type is NEW)

Description:  Taxonomy

Professional License #  Effective Date  Expiration Date

Description:  Taxonomy

Professional License #  Effective Date  Expiration Date

DEA License #  Expiration Date

Medicare Prov No. (DMH directly-operated only)  PPIN Medicare No. (DMH directly-operated only)  Expiration Date

NPI  NPI Effective Date

Authorized Manager/Designee Signature:  SIGNATURE REQUIRED Print Name:  Date:

## CIOB USE ONLY

Rendering Provider IS No:  Ticket #

Date Processed  Processed by:

S  
A  
M  
P  
L  
E