



RENDERING PROVIDER FORM

Request Type

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

General Information

Last Name:

First Name:

Middle Initial: Sex: M F Ethnicity

DMH/NGA Staff Code

FFS Ind Prov No.

SSN

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)

S
A
M
P
L
E

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

Authorized Manager/Designee Signature: Print Name: Date:

CIOB USE ONLY

Rendering Provider IS No: Ticket #

Date Processed Processed by: