



Crisis/Emergency Services Provider Enrollment/Medicaid Reimbursement Request Form

Entity Type	☐ Hospital ☐ Physician Group
Legal Facility Name	

Physical Address	Street Address:		
	City:	State:	Zip Code +4:

Billing Address	Street Address:		
	City:	State:	Zip Code +4:

Contact Name	
Contact Phone Number(s)	
Contact Email Address	

Taxonomy Code	
Tax ID #	
Medicaid #/NPI #(s) <i>(Please list all provider associated Medicaid/NPI pairs you intend to use.)</i>	

Provider Billing Options	
Provider Direct and EDI Electronic Billing Submit the TRADING PARTNER AGREEMENT (TPA) – Electronic Data Interchange (EDI) from our website. This document constitutes an agreement for exchanging EDI between the Trading Partner, provider and Partners Health Management	Paper Claims Process Billing Email Claims_Department@PartnersBHM.org for technical assistance.
Complete fully, scan and send form to Enrollment@PartnersBHM.org .	
Effective Date: _____ (submit form within 90 days of service delivery). Enrollment is valid for one year from effective date.	
Signature of Authorized Provider staff: _____ (must be original signature, not typed)	