PROVIDER INFORMATION UPDATE

* ***Information required for processing***

FOR SENDER USE

Patient Name _____

MRN _____ **Date of Service** _____

* **Physician Name** _____ **Date Sent:**_____

SER # _____

Physician already entered in Provider Dictionary.

YES - Skip to NEW/ADDITIONAL SERVICES or COMMENTS

NO? PLEASE ATTACH COPY OF PRESCRIPTION OR REQUISITION REFERENCING THIS PATIENT

Please provide all the following information:

* *License #* _____ *NYS License? YES NO*

* *NPI#* _____

* *Office Address* _____

_____

_____

* *Phone #* ( ) _____ * *Fax #* _____

*Alternate/Emergency contact #*_____

COMMENTS _____

_____

_____

* **FROM:** _____

(Sender's Name) **Contact # w/ Area code**

_____ _____

(Interoffice Address for Return)

PLEASE SEND TO - **Provider Enrollment**

FAX Number: 607-547-5196

PHYSICIAN REIMBURSEMENT UNIT USE:

Assigned # _____ *Entered by*_____
Mnemonic _____ *Date:* _____
Valid Groups 2 3 4 5