CLEAR FORM

HURRICANE MICHAEL EMERGENT ENROLLMENT FOR PROVIDERS SERVICING DISPLACED RECIPIENTS

Provider Information Sheet

Please complete sections A-D and return to Prestige Health Choice via fax at 1-844-518-2552 or email at PHCPNORequests@prestigehealthchoice.com

A. Contact/Fax Information

Requestor's Name:_____ Phone:_____ Fax:_____

B. Provider Information

(If this a facility please indicate name in "Last Name" field and type of facility in "Provider Type" field)

Last Name: _____First Name:_____MI: _____Title/Degree: _____

Specialty:_____ Provider Type: _____

Florida Medicaid ID (MAID) (required):_____ Out of State providers without a FL Medicaid ID must complete a request for an out of State ID.

State License Number: _____State Issue: _____SSN: _____

DEA Number:_____ UPIN Number:_____ NPI: _____

C. Practice/Service Location Information

Practice Name (DBA): _____ Phone Number: _____

Fax Number: _____ Service Address: _____

City:_____ State: _____ ZIP:_____

D. Billing Group Information

Tax ID Number: _____ Legal Name: _____

Legal Address (where 1099 will be sent): _____ City: _____State: ___ ZIP: _____

Phone Number:_____Fax Number:_____

Billing/Remittance Address (if different from above): _____

City:_____State:_____ ZIP: _____

Phone Number:_____Fax Number:_____

Group NPI: _____ Group Florida Medicaid ID (MAID) (required): _____

E. How to submit the form:

Please return this form to the Prestige Health Choice the complete form along with:

- A copy of the Billing Group W9.
- The letter received from AHCA with the emergency Medicaid.
- (Optional) Electronic Medicaid Electronic Funds Transfer (EFT) Authorization Agreement.

Fax to 1-844-518-2552 or email to PHCPNORequests@prestigehealthchoice.com