This information is needed for the enrollment of claims with our clearinghouse McKesson. Please process this as soon as possible because this information is critical to the filing of electronic claims. When completing please write as legible as possible. Any information that is illegible and subsequently sent to the carrier in error can result in lengthy delays in the electronic claims process. Please note that you must complete one form for every provider. Below you will see an area to provide us with your provider numbers for state payors. If there are any other carriers which require enrollment that you participate with (AG needed = 'Y' on the McKesson payor list), please provide us with their name and your ID numbers for those carriers. When completed, fax back to (803) 736-0733.

1) Legal name of practice

2) Mailing Address

3) Physical Address (write same if same as above)

4) Address on file with the carrier

   Mailing Physical (please circle one)

5) Contact Person / Phone / Fax / Email

6) Full name of provider with title (MD, DO, Etc.)

7) Tax ID ________________________________

8) Individual NPI ________________________ Group NPI____________________________

9) Taxonomy____

10) Signature_________________________________ Date_________________

	CPID	Provider ID	Group ID
Blue Shield			
Medicaid			
Medicare			
RR Medicare			
Tricare			

Information on any other carrier where an agreement is required (please see payor list)

	CPID	Provider ID	Group ID