MEDICARECODING.COM
℞ for Providers' Medicare Pain

Medicare Credentialing Application

(Important Note: ALL Fields are Required)

Type of Credentialing							
Address Change or Provider +/-		New Practitioner		New Practice or Group		Revalidation	

Required Information							
First Name		Last Name					
Company Name							
Street Address				Suite			
City		State		Zip			
Date Started Practicing at this Address?		Mailing Address Different? (If Yes, please note it below)		Yes		No	
Mailing Address				Suite			
City		State		Zip			
Location Type (Check One)							
Group Practice/Clinic		Hospital		Nursing Facility		Other (Specify)	
Email		Social Security #					
Phone Number		Fax Number					
Date of Birth		Place of Birth					
Medical School		Year Grad.					
Primary Specialty							
Provider # (PTAN)		NPI #					
NPI Username		NPI Password					
Do you want to Participate In FL Medicare?		Yes		No			
Bank Contact Name (full)		Bank Phone					

Have you, under ANY current or former name or business identity, EVER had ANY final adverse legal action (convictions, expulsions, revocations or suspensions) imposed against you?
☐ Yes ☐ No
If yes, on separate pages, please explain each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the final adverse legal action documentation and resolution

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If Utilizing a TAX ID #, Creating a New Group Practice or Being Added to a Group, Complete the Following			
Legal Business Name		dBA Name	
TAX ID #		# of Owners	
Group Medicare Provider # (PTAN)		NPI #	

List ALL Officers of Company Entity (Inc, PA, LLC or S-Corp) (attach additional pages as necessary)		
	Owner #1	Owner #2
Name		
Social Security #		
DOB		
State or Country of Birth		
Medicare Provider # (PTAN)		
NPI #		

These Attachments (Copies) are Required PRIOR to Submitting Application to Medicare

✓	Document
	State of FL Medical License
	DEA License
	Medical School Diploma
	Enlarged, readable copy of Driver's License
	CP-575 OR Letter 147C (from IRS)
	List of SPECIFIC Office Hours on your letterhead (for each location if applicable)
	Voided Check

Failure to Provide All Required Information with Result in Delays to Your Medicare Enrollment or Revalidation Approvals!

Complete and Submit to:

FAX: 888.687.2931

Or

relief@medicarecoding.com