

INTEGRATED NEW CLIENT IMPLEMENTATION * REQUIRED INFO

(please write legibly - thank you)

CLIENT :

Client Name: _____

Address: _____

Telephone No: _____ Fax No: _____

Email Address: _____

Owner / Billing Name: _____ Title: _____

Other Store Contacts: _____

MEDICARE : NSC No: _____ participating ? yes no

NAME YOU ENROLLED TO MEDICARE _____ same as above

MULTIPLE LOCATIONS ? yes no use the same information for all locations ? yes no

CMS NPI No : _____

MEDICAID No : _____

NABP No : _____

OTHER No's : _____

TAX I.D. No : _____

MARKETING / AFFILIATION:

UPNI Member KPPA Member PARD Member FPN Member

Competitive Bidding Contractor / Subcontractor NASI-HSN Network

Distributor/Affiliation: _____

Projected Monthly Billings (claim volume): _____ New Provider

Hours: _____

Please completely fill in this document. If the name of your store is different than the name you registered with Medicare, we need both names. This information will be used for medical billings and other customized documents. FAX this document back to Integrated. The number is 7 2 4 - 8 0 5 - 0 0 1 2. You must inform us if anything changes. Thank you.