



### Provider Information Form

To be completed by Provide/Organization during contract completion

1. Provider/Organization Name:	
--------------------------------	--

2. KMAP Provider Number:		YOUR Billing NPI #	
--------------------------	--	--------------------	--

3. Subcontractor (s) to above named organization for whom provider will be billing... <i>include their name and their NPI number:</i>	
<b>Subcontractor Name:</b>	<b>NPI #:</b>

4. What is your capacity for new clients? <i>(Check one box)</i>	<b>0 – 5 clients</b>	
	<b>6 – 20 clients</b>	
	<b>21 – 40 clients</b>	
	<b>More than 40</b>	

5. Who is your Contact Person for your Billing Office:	
Contact Name:	Contact #:

6. What is the Location where Claims Payments should be sent?	
Location Name:	
Location Address:	

7. Would you prefer to receive your payments electronically? <i>(Check box and supply needed information if answer is yes.)</i>		
<b>NO</b>		
<b>YES</b>		
<b>IF Yes</b>		
<b>please provide banking account information for the account you wish to have funds deposited in:</b>		
<b>If checking:</b>	Acct #:	Routing #:
<b>If savings:</b>	Acct #:	Routing #:

8. How would you like to receive your payment vouchers? <i>(Check one box)</i>	
<input type="checkbox"/> 835 Electronic file	<input type="checkbox"/> .pdf file loaded on secure web site
<input type="checkbox"/> Paper	

9. List the Contact Information for each site: <i>Include Contact Type (Claims, Billing, Clinical, etc)</i>		
Location:	Contact Name & Type:	Phone Number:

Provider/Organization Signature:	
Date:	