fax1: 812-759-1524
fax2: 812-468-8478

PROVIDER INFORMATION SHEET - *Quantum Health Automation - 201 NW Fourth Street, Ste 103, Evansville, IN 47708-1356*

Provider NAME:____

BILLING COMPANY:____

HCFA Box 33 Name/PAY TO:__________________________________

Physical Office Name:____

Box 33 Address:____

Physical Address:____

Box 33 City/State/Zip:____

Physical City/State/Zip:____

County:_____________________ Contact:__________________________

Phone Number: (   ) -________ -________ Fax #: (   ) -________-________

Contact E-mail:____

Office Specialty:____________________________Specialty Code:___________

Software Name and Vendor:______________________________________

Taxonomy code(s):____

PROVIDER IDENTIFICATION NUMBERS: *** Tax ID (must be 9 digits):____ ____ ____ ____ ____ ____ ____ ____ ____ (or Soc Security #)

The LIST below are the MAIN carriers of concern. ****** **It is your responsibility to report any provider number ADDITIONS or REVISIONS to QHA** ******

Please ensure that the information indicated below is ACCURATE and LEGIBLE. Clarify Z's and 0's with a slash mark so they are not read incorrectly as 2's or O's.

	Individual provider numbers	Group or Facility provider numbers	State
Medicare			
Medicaid			
Blue Cross/Blue Shield			
RR Medicare			
Medical Mutual of OHIO			
Tricare			
DMERC A B C or D?: (pls circle region)			
Other payer:__________			

State License #:______________________ UPIN:____________________

Premera:_____________________ Regence (WA / OR): ________________

Individual (Type1) NPI:____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Group (Type 2) NPI:____ ____ ____ ____ ____ ____ ____ ____ ____ ____

*** note - national provider identifier is REQUIRED ***

PLEASE CIRCLE ONE OF FOLLOWING: NEW CLIENT   or   EXISTING   (if existing, CLIENT ID: __________________)

Completed by:____ Date: ______ / ______ / 20______

Other information:____

____

____

____

1-800-500-8747
qhaclaims.com