PROVIDER INSURANCE FORM

PLEASE FILL OUT ONE FORM FOR EACH PROVIDER
RETURN TO: FAX (828) 649-9294
IF PROVIDER IS NOT PARTICIPATING, PLEASE WRITE N/A IN THE APPROPRIATE BLOCK.

PRACTICE/GROUP NAME:
PROVIDER NAME:
PAY TO ADDRESS:
CITY, STATE, ZIP CODE:
PHONE NUMBER:
FAX NUMBER:
E MAIL ADDRESS:
PROVIDER EIN#:
SOCIAL SECURITY #:
UPIN #:
LICENSE #:
SPECIALTY:
TYPE OF OFFICE (i.e. group):

INSURANCE NAME	PROVIDER ID#	GROUP #	STATE
MEDICARE			
MEDICARE RAILROAD			
MEDICAID			
BLUE CROSS			
BLUE SHEILD			
TRICARE			
OTHERS: PLEASE LIST:			

SIGNATURE__________________________________ DATE________________________________