Payerpath Registration – Form FA-39

Request Type: ☐ New* ☐ Update *If this is a new request, please attach form FA-37 (Service Center Authorization)		
Business name:		
Business address (include city, state and zip code:		
Business contact (first and last):		Phone:
Provider specialty:		Federal tax ID number:
What is the name of your internet service provider?		
Do you currently use practice or hospital management software? ☐ Yes ☐ No	Do you use the web browser Internet Explorer 8.0 or higher? ☐ Yes ☐ No	
What is your average number of Medicaid claims per month?	Which claim form do you use? ☐ CMS-1500 ☐ UB ☐ ADA	
How many providers from your practice/business/facility will be submitting claims under this Payerpath account?		
Primary User (first and last name):		
Phone:	Fax:	E-mail:
Secondary User (first and last name):		
Phone:	Fax:	E-mail:
Tertiary User (first and last name):		
Phone:	Fax:	E-mail:

On the following lines, enter information about each provider who will be submitting claims using this Payerpath account. List each provider's name, 10-digit NPI/API and the 10-digit NPI/API of the group that provider is associated with (when applicable). Attach additional sheets if necessary to list all providers.

	Provider Name	NPI/API	Group NPI/API
1			
2			
3			
4			
5			

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	Provider Name	NPI/API	Group NPI/API
6			
7			
8			
9			
10			
11			
12			