TRIZETTO Provider Solutions
A Cognizant Company

SITE ID
Required
337G

MEDICAL OFFICE PROVIDER ENROLLMENT FORM

Please complete and return via email to enrollassist@cognizant.com within 3-5 business days. If you are unable to email this form, please fax it to 314-898-1913.

Contact Name:	Phone:
Email:	Fax:
EDI _____ ERA _____	

The information provided on this form MUST match what is on file with the payers.

Group Information (if applicable)	Provider Information
Group Name:	First Name:
	MI:
DBA (if applicable):	Last Name:
	Title:
Group NPI:	Individual NPI:
Specialty:	Tax ID:

Service Location Address	Pay To Address (if different)
Street Address:	Street Address:
City, State, Zip +4:	City, State, Zip +4:

***Indicate below the Individual and/or the Group Provider numbers, legacy ID's or PTANS issued by the payers. *** Although these IDs may not be used on the claims, they are often required for EDI enrollment.

Insurance Company	Group Provider Number	Individual Provider Number