TRIZETTO Provider Solutions

SITE ID: 337G
Required

MEDICAL OFFICE PROVIDER ENROLLMENT FORM

Please complete and return via email to enrollassist@trizetto.com
If you are unable to email this form, please fax it to 314-802-6913.

Please note the turnaround time for approval is 10 Business Days, you will be notified by Email or Fax, if you have a preference please indicate on the form.

Contact Name:	Phone:
Email:	Fax:

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:
Tax ID:	Specialty:

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	Payer ID	Group Provider Number	Individual Provider Number
Managed Healthcare Administration - Blue Choice	MHCA2		
Managed Healthcare Administration - EPS	MHCA1		