



ASIAN AMERICAN MEDICAL GROUP (AAMG1) 835 ENROLLMENT REQUEST

Email this form to ProviderServices@excelmso.com or Fax to (408) 937-3639. Please make sure to print legibly and to complete this form in its entirety. You risk delaying enrollment if the application is unreadable or incomplete.

PROVIDER INFORMATION:

Provider Name:

Provider Address:

PROVIDER IDENTIFIER INFORMATION:

**Provider Federal Tax Identification Number (TIN)
OR Employer Identification Number (EIN):**

National Provider Identifier (NPI):

PROVIDER CONTACT INFORMATION:

Provider Contact Name:

Telephone Number:

Email Address:

ELECTRONIC REMITTANCE ADVICE INFORMATION:

**Preference for Aggregation
Of Remittance Data:**

Note: Account Number Linkage to Provider Identifier. Must match preference for EFT payments.

SUBMISSION INFORMATION:

Reason for Submission:

Authorized Signature:

Note: Electronic Signature (typed name) of Person Submitting ERA Enrollment.