



# PMGSJ / EXCEL MSO (EXC01) 835 ENROLLMENT REQUEST

Email this form to [Providerservices@excelmso.com](mailto: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:**

**City:**

**State:**

**Zip:**

## 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/Ext:**

**Email Address:**

**Fax Number:**

## ELECTRONIC REMITTANCE ADVICE INFORMATION:

**Preference for Aggregation of Remittance Data:** (i.e. Account Number Linkage to Provider Identifier). Provider preference for grouping (bulking) claim payment advice must match preference for EFT payment (i.e. Billing Provider). Choose only one.

Provider Federal Tax Identification Number (TIN):

National Provider Identifier (NPI):

## SUBMISSION INFORMATION:

**Reason for Submission:**

**Authorized Signature:**

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