
Submit the completed Payer Request Form to:

ABILITY Network, ATTN: Enrollment
FAX: 888.837.2232 | EMAIL: setup@abilitynetwork.com

INSTRUCTIONS

- Complete all sections of the form if
 - You are a billing service completing this form on behalf of a provider
 - You use a billing service to prepare your claims
- If you do not use a billing service to prepare your claims, complete only the Provider Information section of the form. ABILITY Network is not a billing service.
- Indicate whether you are a Professional or Institutional provider
- Indicate whether this is a new enrollment or you are changing enrollment information with ABILITY Network
- Complete this form using group provider information as listed on file with the payer you wish to set up
- Include the billing TAX ID and indicate whether it is a TIN/EIN or SSN. Indicate the billing NPI.
 - If you are unsure what information payers have on file for you, contact the payers – ABILITY Network cannot obtain this information for you

Note: Some payers require additional documentation to be completed and signed by the provider in order to complete enrollment. Some payers require enrollment agreements to set up enrollment. Please refer to the payer list at abilitynetwork.com/payer-list for additional enrollment requirements.

IMPORTANT: You must specify the payer(s) with which you wish to enroll. If no payers are specified, enrollment forms WILL BE RETURNED.

If you wish to receive ERA from any additional payers, add them in the space provided.
Make copies of this form if necessary.

Questions or need assistance?

Contact ABILITY Network Enrollment Department at 888.499.5465 or setup@abilitynetwork.com.



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INSTRUCTIONS

Complete one form per TAX ID. Return this form with your EDI documentation. All information is required unless you are NOT using a billing service - ABILITY Network is not a billing service. Note: Some payers require additional enrollment forms - please review our payer list for additional requirements.

BILLING INFORMATION

Please type your responses directly into the form.

New Request

Change Request

Billing Service Name

TIN or ABILITY ID:

Contact Name:

Phone: ()

Fax: ()

Email:

Group/Provider Name:

Please check for designation:

Professional

Institutional

Billing Tax ID or SSN:

Billing NPI:

Street Address:

City:

State:

Zip:

Name of Authorized Signee:

Title of Authorized Signee:

PROVIDER INFORMATION

List carriers/providers with which you wish to enroll below. Please refer to the ABILITY Network Payer List for enrollment requirements.

Table with 7 columns: Payer ID, Payer Name, PTAN, Individual Provider Name, Rendering NPI, Claims, ERA. The table contains 7 empty rows for data entry.

Questions or need assistance?

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