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
Intercommunity Health Net	INCHN		