



Electronic Claims Submission Enrollment

Group Name: _____

Or

Individual Provider's Name with Credentials: _____

(If not part of a group)

Tax ID Number: _____

National Provider Id Number (Individual): _____

National Provider Id Number (Group): _____

Provider Specialty: _____

Type of claims being sent: Professional (HCFA), Institutional (UB92)

Vendor Name: _____

Vendor Contact Name and Phone Number: _____

Vendor Contact Email: _____

Provider Billing Address

Physical Address

(If different than billing address)

Provider Contact Name and Phone Number: _____

Provider Contact Email: _____

Form Completed By: _____

Date: _____

Return completed form to aultcare-is@aultman.com

To view the current AultCare 837 companion guide go to www.aultcare.com