AULTCARE

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