Provider /Organization NPI Submission

Please complete a separate form for each payer listed below

☐ Blue Cross and Blue Shield of Minnesota, BCBSM PDO, R3-19, P.O. Box 64560, St. Paul, MN 55164-0560
Fax: (651) 662-6684

☐ HealthPartners, P.O. Box 1309, Mail Stop: 21108C, Minneapolis, MN 55440-1309
Fax: (952) 883-5665

☐ Medica, P.O. Box 9310, Minneapolis, MN 55440-9310
Fax: (952) 992-3802

☐ Metropolitan Health Plan, 822 South Third Street, Suite 140, Minneapolis, MN 55415
Fax: (612) 904-4522

☐ Minnesota Department of Human Services (DHS), Provider Training and Enrollment, P.O. Box 64987, St. Paul, MN 55164-0987
Fax: (651) 431-7462

☐ PreferredOne Administrative Services, P.O. Box 59212, Minneapolis, MN 55459-0212
Fax: (763) 847-4010

☐ UCare Minnesota, Attn: Credentialing, P.O. Box 52, Minneapolis, MN 55440-0052
Fax: (612) 884-2184

Today's date: __________ *All fields are required*

Name of person submitting this form: __________

Phone: (   )

PROVIDER INFORMATION

Current Provider Number * (ID Assigned by Payer checked above)	
Name:	
Specialty:	
Street Address	
City, State, ZIP	

Individual Practitioner (Type 1)

SSN: __ __ __ - __ __ - __ __ __ __

NPI: __ __ __ __ __ __ __ __ __ __

Organization (Type 2)

TIN: __ __ - __ __ __ __ __ __ __

NPI: __ __ __ __ __ __ __ __ __ __

☐ Check this box if your organization has been assigned an NPI for a single Current Provider Number.

☐ Check this box if the NPI is associated with more than one Current Provider Number (see instructions).

☐ Check this box if multiple NPIs are associated with the Current Provider Number (see instructions).

☐ Check this box if none of the above applies or if you are unsure.

Instructions for completing the Provider/Organization NPI Submission Form

Check only one box for the appropriate payer. Please complete a separate form for each payer.

Please send or fax the completed form to the fax number or address listed for each payer.

Today's Date – Enter the date that you are completing this form.

Name of person submitting this form – Enter your name as the submitter. This is the person that will be contacted if there are any questions about the information on this form.

Phone – This is the phone number for the person completing the form. Please include the area code.

Provider Information

Current Provider Number – This is the payer specific provider number. If you are completing this form for an individual practitioner, enter the Individual Practitioner Number. If you are submitting this form on behalf of a facility or group practice, enter the Group Contracting Provider Number. *If you are completing this form for individuals as well as for a facility or group practice, please fill out separate forms – one for each Individual Practitioner Number and one for the Group Contracting Provider Number.*

Name – If you are completing this form on behalf of an individual practitioner, enter the person's name. If you are submitting the form on behalf of a facility, enter the facility's name.

Specialty – If you are completing this form on behalf of an individual practitioner, enter the individuals' specialty. If you are submitting this form on behalf of a facility, enter the specialty of the facility.

Street Address – Enter the street address for the practice location.

City, State, ZIP – Enter the City, State and ZIP for the practice location.

Individual Practitioner (Type 1)

SSN – Enter the individual's Social Security Number

NPI – Enter the individual practitioner's National Provider Identifier. The NPI must be 10 numeric digits.

Organization (Type 2)

TIN – This is the tax identification number for the facility in which this form is being completed for.

NPI – Enter the National Provider Identifier for the facility. The NPI must be 10 numeric digits.

Checkboxes:

- If the NPI has one single Current Provider Number, check the first box.
- If the NPI is associated with more than one Current Provider Number, check the second box. Please include all Provider Numbers (for this payer only) that are associated with the NPI.
- If there is more than one NPI associated with the Current Provider Number, check the third box. Please include all NPIs along with the associated name, specialty, street address, city, state and ZIP.
- If none of the options described above apply or if you are unsure, check the fourth box. You will be contacted at the phone number indicated on the form.