Nurse Practitioner/Physician Assistant Registration Form

(Please complete one form for each tax entity for which you work by circling the appropriate response or filling in the blank with the requested information. If you practice at more than two locations, please attach another copy of the form indicating only the additional locations on the attached form. Call 327-2348 with questions.)

Effective Date ________________________

1. Last name: ______________________ First name ____________ MI __
2. Date of birth: ______________________ Gender: M F
3. Certification: Nurse Practitioner Physician Assistant
4. Name of Graduate School: ____
5. Your Specialty: ____________________ Degree: ____________________
6. NYS License #: ____________________ Year Obtained: _________________
7. DEA # : ______________________
8. Medicaid #: ___________ Medicare #: ___________ NPI #: ______________
9. Languages you speak: ____
10. Supervising physician: ____
11. Primary office address: ____

    City: __________________ State: ______ Zip: ____________________

    Phone : (___) ____________ Answering service phone: ___________________

    Fax: (___) _______________ E-mail address: __________________________

    Employer/Practice Tax ID number: ____________________________________
12. Secondary office address: ____________________________________

    City: __________________ State: ______ Zip: ____________________

    Phone : (___) ____________ Answering service phone: ___________________

    Fax: (___) _______________ E-mail address: __________________________
13. Policyholder of Malpractice Insurance:
    Self Physician/Practice Other: ____________________

Signature of NP/PA: __________________________________ Date: ________

After completing and signing the form, please attach a copy of your license, DEA certificate, and malpractice insurance and send to:

MVP Health Care
Network Management Dept.
220 Alexander Street
Rochester, NY 14607

or fax to 585-327-2289

Office use only	MC Provider #: ____________
Input date: ________	A-SYS Provider #: __________
Products: __________	Initials: ____________