National Provider Identifier Application Form

Name:_____Suffix_____
(first, middle, last) (Jr/Sr)

Have you already applied for an NPI number? _____ (Yes or No)

If yes, please indicate the 10 digit NPI number you were assigned:_____
If you have an NPI number, stop here with this form and attach a copy of your confirmation from NPPES.
If you do not have an NPI number proceed to the questions below.

Identifying Information:

Credential type/Staff classification _____

Date of birth_____ State of birth_____ Country of birth_____

Gender: Male____ Female____

Social Security Number:_____

Mailing Address Information:

Street_____

City_____State_____Zip_____

Provider Service Location: **Service Location telephone**_____

Street_____

City_____State_____Zip_____

Other Provider Identification Numbers:

Number Type	Number	State(if applicable)	Issuer
UPIN	_____	_____	
Medicare	_____	_____	
Medi-cal	_____	_____	
Other	_____	_____	_____
Other	_____	_____	_____
Other	_____	_____	_____

License Number:_____ Type_____

State where Issued:_____ Expiration date:_____

I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.

Applicant's signature_____Date_____