RCIPA
Rochester Community Individual
Practice Association, Inc.

VERSION 10-20230-v1

RCIPA Provider Enrollment Form
Email to rcipainfo@rcipa.com or fax to 585-287-9982

**Provider Effective Date
With the Practice TIN**

The Provider Enrollment Form should be used for a single TIN (tax identification #); if the provider has more than one TIN, please use a separate Provider Enrollment Form for each TIN.

NOTE: please pay special attention to Dept., Practice, Group Name as this information assists in assigning the provider to the correct practice location in the RCIPA system.

Provider Type (please circle) ☞ **Community-based provider** **Hospital-based provider**
Community-based providers are providers for which patients can schedule appointments to be seen by the provider.
Hospital-based providers are providers that do not schedule patient appointments e.g. pathologists, ED, hospitalists etc.

/ /

⇧ **Provider Name** (last / first / middle) *please print*

M F

⇧ **Date of Birth** (mm/dd/yyyy) | ⇧ **Gender** (please circle) | ⇧ **Title** (MD, PhD, etc.)

⇧ **Individual NPI** (10 digits) | ⇧ **NY State License** (6 digits) | ⇧ **Lic. Expire Date** (mm/yyyy) | ⇧ **CAQH PIN** (8 digits)

⇧ **Primary Specialty** | ⇧ **Other Specialty** (if applicable)

⇧ **Billing TIN (tax id # 9 digits)** | ⇧ **Legal (W9) Tax Name** | ⇧ **DBA**

⇧ **Billing Address** (street, city, state, zip code) | ⇧ **Billing Telephone #**

⇧ **Practice 1 Address** (street, suite # city, state, zip code) | ⇧ **Practice 1 Telephone #**

⇧ **Practice 1 Department or Group Name** (e.g. Dept. of Pediatrics, ABC Physical Therapy) | ⇧ **Practice 1 Fax #**

⇧ **Practice 2 Address** (street, suite #, city, state, zip code) | ⇧ **Practice 2 Telephone #**

⇧ **Practice 2 Department or Group Name** (e.g. Dept. of Pediatrics, ABC Physical Therapy) | ⇧ **Practice 2 Fax #**

⇧ **Practice 3 Address** (street, suite #, city, state, zip code) | ⇧ **Practice 3 Telephone #**

⇧ **Practice 3 Department or Group Name** (e.g. Dept. of Pediatrics, ABC Physical Therapy) | ⇧ **Practice 3 Fax #**

⇧ **Practice 4 Address** (street, suite #, city, state, zip code) | ⇧ **Practice 4 Telephone #**

⇧ **Practice 4 Department or Group Name** (e.g. Dept. of Pediatrics, ABC Physical Therapy) | ⇧ **Practice 4 Fax #**