SYSTEMS DESIGN
Billing Solutions Since 1989

Provider Information Form – established providers

The information on this form helps us update your existing enrollments. This form is fillable & savable if you have Adobe Reader installed on your computer.

LEGAL BUSINESS NAME	DBA NAME
MAILING ADDRESS	**PHYSICAL ADDRESS (HQ/MAIN STATION)**

Primary Phone #: **Primary Fax #:** **Other Contact # (if any):**

Date of First Billing: **Tax ID:** **NPI:** **Medicare #:**

EMS License #: **Issue Date:** **Expiry Date:** **Business License # (if applicable):**

Authorized Signers & Other Contacts

1 = AO 2 = DO 3 = OC	Title	Name	DOB	SSN	Phone	Email	Date started in current position

1 - Authorized Official (AO) - Authorized to bind agency to a Federal Contract (Chief, CFO, City Manager).
2 - Delegated Official (DO) - Typically the Administrative Assistant or other personnel who works closely with EMS billing. Delegated to maintain Medicare file.
3 - Other Contacts (OC) - Personnel who will work with the billing agency on a regular basis (SSN/DOB is NOT required).

REQUIRED ATTACHMENTS

You must provide copies of:

- ☐ EMS License(s)
- ☐ Certificate of Liability Insurance
- ☐ IRS Form CP575 or LTR 147C
- ☐ Bank Account information:
  - Must be printed on your bank's letterhead
  - Must indicate account holder (name must match IRS doc EXACTLY)
  - Must indicate account type (Savings, Checking, etc.)
  - Must indicate routing & account numbers
  - Must be signed by bank official (NO digital signatures allowed)

BLS-only Providers:

Do you have a written agreement with an ALS agency for their crew to ride along and provide ALS services?

☐ NO.

☐ YES. A copy of the agreement is attached.

PROVIDER NUMBERS

If you are actively billing, you are already enrolled with major health insurance agencies. List all your provider numbers below where applicable.
You may need to consult with your current biller for these details. The transition from your current biller to Systems Design will be smoother if this information is complete.

Payer	Provider #
Alaska Medicaid	
California Medicaid	
Idaho Medicaid	
Oregon Medicaid	
Montana Medicaid	
Washington Medicaid (DSHS)	
Office of Workers' Compensation	
Railroad Medicare	
WA Labor & Industries	
Federal UEI (Unique Entity ID)	

Other contracted payers (please provide copies of contracts if applicable)

PAYMENT SETUP In order to re-direct remits and claim-related correspondence to Systems Design, indicate the current payment setup for each payer.			
Payer	**Payment Method (Check, EFT, Virtual Credit Card, etc.)**	**Payment Address on file with Payer**	**If paid by check, want to enroll for EFT? (Y/N)**