

NPI VERIFICATION FORM

SECTION I (Please verify that the following pre-populated information is correct)

Provider/Company Name: _____ **Tax ID#:** 000000000
MCI: XX0000 **Medicare No:** 0000XXXXX
 (Medicaid ID #)

Service Address <input type="checkbox"/> OK AS IS	Pay-to Address <input type="checkbox"/> OK AS IS
Provider/Company Name:	Provider/Company Name:
DBA:	DBA:
Address:	Address:
City:	City:
State:	State:
ZIP+4:	ZIP+4:

- Did not obtain an NPI because I/we are not a healthcare provider.
- Did not obtain an NPI because I/we do not conduct electronic claims, eligibility lookups, or other HIPAA-covered transactions.
- Have not yet obtained an NPI but will be doing so by _____.
- We no longer use this Provider ID Number.

If you checked a box, skip to Section III to provide current contact information.

SECTION II (NPI/Subpart NPI and Subpart Description(s) associated with the Medicaid Contract Identification (MCI) number at the top of this form)

A. Provider NPI/Subpart NPI	A. Provider NPI/Subpart NPI	A. Provider NPI/Subpart NPI
B. Taxonomy Code(s) Associated with the above NPI	B. Taxonomy Code(s) Associated with the above NPI	B. Taxonomy Code(s) Associated with the above NPI
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

SECTION III

Print or Type Name of Provider or Authorized Representative:	Provider or Authorized Representative Contact Phone Number: ()
Provider or Authorized Representative Signature: X	
Provider or Authorized Representative Title:	

Please return this NPI Verification form **by mail** to Affiliated Computer Services at the following address:

**Affiliated Computer Services, Inc., ATTN: Provider Enrollment Unit
 P.O. Box 240808, Anchorage, AK 99524-0808**

For any questions, please call the Affiliated Computer Services' Provider Enrollment Unit at (907) 644-6800 or (800) 770-5650 (in-state toll free).