Insurance Benefit Spot Check, Inc.

Provider Registration Form

Site and Provider Information

Practice Name:____

Address:____

City, State, Zip:____

Contact Name:____________ **Phone:**(_ __)________ **Fax:**(__ __)________

Provider Tax ID:________________

Medi-Caid Provider Number:________________

Blue Cross/Blue Shield Provider Number:________________

Medicare Part A Providers

Hospital Medicare Part A access: To obtain access to Medicare Part A files via SPOTCHECK please supply us with the information in this section. Due to password conflicts, please do not use this User ID and password with the DDE system. IBSC will manage password changes for this pairing.

Medicare Provider #: ________ **Part A user ID:** ________ **Password:** ________

Bill To *(If different then above)*

Name: ________________________________

Address: ________________________________

City, State, Zip:________________________________

Contact Name:____________ **Phone:**(__ __)________ **Fax:**(_ __)________

Additional Site Locations

If more then one product is ordered, please let us know where you plan to place each product, include the address and telephone number for locations different then above.

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