**Please Complete the Vendor ID Form and Submit to Provider Relations.**

|  |
| --- |
| **Section 1: Provider Specific Information** |
| **CLASSIFICATION** |
| **\*Classification** |
|  **Individual Provider**  (Clinician)   **Group Provider Practice** (Agency) |
| **\*Select Type of Service(s) Provider Currently Rendering**  |
|  **Residential Supports**      **Day Program**      **Professional Clinical Services**      M**iscellaneous Services**      |
| **Please explain Type of Service(s) Provider Currently Rendering (Prior to DC Medicaid Final Approval)****Please explain Type of Service(s) Provider will render (After DC Medicaid Final Approval)** |
| **Section 2: Provider Information** |
| **\*Provider Name:** |
| **Doing Business As Name (DBA):** |
| **PROVIDER MAIN ADDRESS** |
| **\*Street:** |
| **\*City:** |  | **\*State:** |  | **\*Zip:** |  |
| **Section3: PROVIDER IDENTIFIERS INFORMATION** |
| **PROVIDER IDENTIFIERS** |
| **\*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):** |  |
| **National Provider Identifier (NPI):** |  |
| **Taxonomy Number:** |  |
| **DC Business License Number:** |  |
| **Are you a CBE in the District of Columbia?** |  |
|  |  |
| **OTHER IDENTIFIER(S)** |
| **\* Medicaid Provider ID:** |
| **\*State:** | **Approval Date:**  |
| **Section 4: PROVIDER CONTACT INFORMATION** |
| **\*Provider Contact Person Name:** |
| **Title:**  |
| **\*Telephone Number:** | **Telephone Number Extension:** |
| **Alternate Telephone Number:**  | **Fax Number** |
| **\*Email Address:**  |
| **Provider Web Address:**  |
| **Section 5: PROVIDER OPERATION INFORMATION** |
| **\*Provider Years of Operation:** |
| **CEO/ Owner:** | **CFO/ Accountant:** |
| **Program Director:**  | **Quality Management Director:** |
| **Medical Director:** | **Incident Management Director:** |
| **Section 6: SUBMISSION INFORMATION** |
| **\*Reason for Submission:** |
|  **New Enrollment**      **Supplemental Enrollment**      **Re-Enrollment**     |
| **AUTHORIZED SIGNATURE I hereby declare that the information provided is true and accurate in all respects.**  |
| **\*Printed Name of Person Submitting Vendor Form:** |
| **\*Printed Title of Person Submitting Vendor Form:** |
| **\*Submission Date:** |
| **Signature:** |