**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:** | | | | | |