RIte Share Co-Insurance and Deductible Only
Individual Provider Enrollment Form

Please note that completing this form is not necessary if you are already an enrolled provider with RI Medicaid.

Provider Name	**Last Name**	**First Name**	**Middle Initial**	**Title**
Tax ID Number	**Individual**			
Office Address	**Street**			**Suite/Room**
	City		**State**	**ZIP**
	Contact Name		**Title**	**Phone**
Pay To: Address	**Street**			**Suite/Room**
	City		**State**	**ZIP**
	Contact Name		**Title**	**Phone**
Mail To: Address	**Street**			**Suite/Room**
	City		**State**	**ZIP**
	Contact Name		**Title**	**Phone**
Provider Signature:	_____ **Sign**			**Date**

Individual providers, establishing a practice, please include:

- **License**
- **W-9, signed**
- **Provider Agreement, signed**
- **Electronic Funds Transfer (EFT) form**
- **EFT Back up**
- **A copy of the NPI letter from CMS that contains your NPI and Taxonomy number**
- **Addendum I, signed**
- **RI Medicaid Disclosures**
- **Exclusion Letter**