STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
ADDING MEMBERS TO A NEW OR EXISTING GROUP PROVIDER APPLICATION

Group Name:		**Group National Provider Identifier (NPI) Number:**	
Service Location Address:		**Group Taxonomy (ies):**	
		Group Tax Identification Number:	
Pay To Address:		**School Dept. Tax Identification Number:**	
Mail To Address:			
Phone Number:		**RI Medicaid Use Only**	
Fax Number:		**Census Track:**	**County Code:**
Group Email address:		**Town Code:**	**Location Code:**

NEW GROUP MEMBERS:

I understand fully the standard of participation as stated in the State of Rhode Island, Executive Office of Health and Human Services, Provider Agreement Form (enclosed in enrollment packet) and will participate in the Rhode Island Medicaid Program in accordance with these standards.

PROVIDER NAME	SOCIAL SECURITY NUMBER	EFFECTIVE DATE w/GROUP	NATIONAL PROVIDER IDENTIFIER	TAXONOMY(S)	LICENSE #	PROVIDER TYPE & SPECIALTY	SIGNATURE	DATE

Signature of Provider, Senior Partner, or Chief Corporate Officer of Group **Title**
Please Note: Original signatures are required. Photocopies and stamped signatures are not accepted.

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED*****