Savant Medical Billing

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Group Practice Intake Form

Primary Business Name: _____

Provider Full Name: _____

TAX ID: _____ NPI: _____ EIN: _____

Group Tax ID: _____Group NPI: _____

Business License #: _____ State License #: _____

Business Phone: _____ Fax: _____

Email: _____ Web-site: _____

Primary mailing address for payments:

_____

City, State and Zip: _____

1. Place of service business address:

_____

City, State and Zip: _____

2. Place of service business address:

_____

City, State and Zip: _____

Insurance Identifiers:

CAHQ ID: _____ BCBS OAID: _____

Medicare Provider ID: _____ Medicaid Provider ID: _____ (OR/WA)

Labor and Industries Provider ID: _____

Any other special Identifiers: _____

Web-site access to insurance carriers

1. **Availity** - Provider agrees to grant **User name: SavantMB** access to their Availity account.
2. **Office Ally** - If you already have an account have our security administrator create a login for Savant Medical Billing, Susanne Noga. Email to: savantmedicalbilling@gmail.com,
   If you don't already have an account we will get one set-up for you, if needed.
3. **Onehealthport** – SMB will nominate you as a subscriber under SMB parent account.
4. **NaviNet** – User name: _____ PW:_____
5. **OPTUM** - User name: _____ PW:_____
6. **Other Programs** – Provide SMB with and other usernames and passwords that will be need to coordinate billing services for your practice in the area below here.

User name: _____ PW:_____

User name: _____ PW: _____

User name: _____ PW: _____

User name: _____ PW: _____

User name: _____ PW: _____

List all providers working under the Group Tax ID:

If contracting is different for each provider please complete Page 2 for each provider.

Provider Name: _____ NPI: _____

Provider Name: _____ NPI: _____

Provider Name: _____ NPI: _____

Provider Name: _____ NPI: _____

Provider Name: _____ NPI: _____

Provider Name: _____ NPI: _____

I _____, herby authorize Savant Medical Billing (SMB) to process claims, set-up clearinghouse and web-site access to gather insurance and government agency information on my behalf relating to the normal course of business to process claims, collect fees and manage patient accounts.

_____ _____

Client Signature **Date**

Medical Insurance

✓ Check mark all carriers you are in network with, does this apply to all providers in your office? If not, have each provider complete this form.

Provider Name:_____ **Provider NPI**: _____

	Aetna		Lifewise WA
	ASHN		Medicare
	BCBS		Medicaid Oregon
	BCBS FED		Medicaid Washington
	Beacon		MHN
	CHP		Molina
	CHPW		ODS/ MODA
	Coordinated Health Care		OPTUM
	Cigna		PacificSource
	Coventry Health		Premera Blue Cross
	EBMS		Providence Preferred PPO
	First Choice Health		Providence Health Plan
	Health Net		Regence Oregon (Local)
	Heathway's		Regence Group Administrators
	HMA		Tri-Care Military
	Humana		UMR
	ILWU Local 21		United Health Care
	Kaiser Permanente		United Health Care Medicare Advantage
	KPS		Value Options
	Lifewise OR		Zenith Administrators

Anything else SMB needs to know about your practice affiliations, or special considerations?

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