National Disaster Medical System
Definitive Care Reimbursement Program
Provider Enrollment Form

Legal Name of Business or Individual:

Trade or "D/B/A" Name if applicable:

IRS Employer Identification Number (EIN):

Physical Street Address:

City, State and Zip Code:

National Provider Identifier (NPI) Number:

Medicaid Provider Number and State:

Medicare Provider Number (CMS Certification Number CCN):

Contact Person:

Contact Person Company Name:

Is the Contact Person with a 3rd Party Billing Service?:

Contact Person's Phone Number:

Contact Person's Fax Number:

Contact Person's E-mail Address:

Contact Person's Mailing Address:

Contact Person's City, State and Zip Code:

Authorization:

By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions with the effective date of the EFT authorization. You must notify Apprio Inc. regarding any changes in the account in sufficient time to allow Federal Fiduciary to act on the changes.

Authorized/Delegated Official Name:

Authorized/Delegated Official Telephone #:

Authorized/Delegated Official Title:

Authorized/Delegated Official E-mail Address:

Authorized/Delegated Official Signature:

Date Signed:

Please mail or fax this completed form along with the ACH Vendor Enrollment form to:

NDMS Definitive Care Reimbursement Program
c/o Apprio Inc.
425 3rd Street, SW
Suite 890
Washington, DC 20024
Fax: 888.587.2352