

NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form.

SECTION 1 – BASIC INFORMATION

A. Reason For Submittal Of This Form (Check the appropriate box)

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. <input checked="" type="checkbox"/> Initial Application
2. <input type="checkbox"/> Change of Information (See instructions)
NPI No. _____ | 3. Deactivation NPI No. _____
REASON (Check one of the following)
<input type="checkbox"/> Death <input type="checkbox"/> Business Dissolved
<input type="checkbox"/> Other _____ |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

B. Entity Type (Check the appropriate box)

1. An individual who renders health care. (Complete Sections 2A, 3, 4A and 5)
 2. An organization that renders health care. (Complete Sections 2B, 3, 4B and 5)

SECTION 2 – IDENTIFYING INFORMATION

A. Individuals

1. Prefix (e.g., Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	

Other Name Information (If applicable. Use additional sheets of paper if necessary)

7. Prefix (e.g., Major, Mrs.)	8. First	9. Middle	10. Last
11. Suffix (e.g., Jr., Sr.)		12. Credential (e.g., M.D., D.O.)	

13. Type of other Name
 Former Name Professional Name Other (Describe) _____

14. Date of Birth (mm/dd/yyyy)	15. State of Birth (U.S. only)	16. Country of Birth (If other than U.S.)
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17. Gender
 Male Female

18. Social Security Number (SSN)	19. IRS Individual Taxpayer Identification Number
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B. Organizations and Groups

1. Name (Legal Business Name)	2. Employer Identification Number (EIN) or SSN
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3. Other Name (Use additional sheets of paper if necessary)

4. Type of Other Name
 Former Legal Business Name D/B/A Name Other (Describe) _____

SECTION 2 – ADDRESSES AND OTHER INFORMATION

A. Mailing Address Information

1. Mailing Address Line 1 (Street Number and Name or P.O. Box)

2. Mailing Address Line 2 (Address Information; e.g., Suite Number)

3. City	4. State	5. ZIP+4 or Foreign Postal Code
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6. Country Name (if outside U.S.)

7. Telephone Number (Include Area Code & Extension)	8. Fax Number (Include Area Code)
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B. Practice Location Information

1. Primary Practice Location Address Line 1 (Street Number and Name – P.O. Boxes Not Acceptable)

2. Primary Practice Location Address Line 2 (Address Information; e.g., Suite Number)

3. City	4. State	5. ZIP+4 or Foreign Postal Code
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6. Country Name (if outside U.S.)

7. Telephone Number (Include Area Code & Extension)	8. Fax Number (Include Area Code)
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C. Other Provider Identification Numbers *(Use additional sheets of paper if necessary)*

Number Type	Number	State (if applicable)	Issuer (Other type)
UPIN	_____		
Medicare	_____	_____	
Medicaid	_____	_____	
Other	_____	_____	_____
Other	_____	_____	_____

D. Provider Taxonomy Code *(Provider Type/Specialty. Enter one or more codes)* **and License Number Information**

Information on provider taxonomy codes is available at www.wpc-edi.com/taxonomy. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity.

1. Primary Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

2. License Number	3. State where issued
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4. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

5. License Number	6. State where issued
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7. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

8. License Number	9. State where issued
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**PENALTIES FOR FALSIFYING INFORMATION ON THE
NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM**

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

SECTION 4 – CERTIFICATION STATEMENT

I, the undersigned, certify to the following:

- This form is being completed by, or on behalf of, a health care provider as defined at 45 CFR 160.103.
- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.
- I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.
- I have read and understand the Penalties for Falsifying Information on the NPI Application/Update Form as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.

A. Individual Practitioner’s Signature

1. Applicant’s Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	2. Date (mm/dd/yyyy)
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B. Authorized Official’s Information and Signature for the Organization

1. Prefix (e.g., Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	
7. Title/Position			8. Telephone Number (Area Code & Extension)
9. Authorized Official’s Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)			10. Date (mm/dd/yyyy)

SECTION 5 – CONTACT PERSON

A. Contact Person’s Information

- Check here if you are the same person identified in 2A or 4B.
If you checked the box, complete only item 8, e-mail address in this section (Section 5).

1. Prefix (e.g., Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	
7. Title/Position	8. E-Mail Address	9. Telephone Number	

For the most efficient and fast receipt of your NPI, please use the web-based NPI process at the following address: <https://nppes.cms.hhs.gov>. NPI web is a quick and easy way for you to get your NPI.

**Or send the completed application to: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0931. The time required to complete this information collection is estimated to average 20 minutes per response for new applications and 10 minutes for changes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Do not send the applications to this address.

PRIVACY ACT STATEMENT

Section 1173 of the Social Security Act authorizes the adoption of a standard unique health identifier for all health care providers who conduct electronically any standard transaction adopted under 45 CFR 162. The purpose of collecting this information is to assign a standard unique health identifier, the National Provider Identifier (NPI), to each health care provider for use on standard transactions. The NPI will simplify the administrative processing of certain health information. Further, it will improve the efficiency and effectiveness of standard transactions in the Medicare and Medicaid programs and other Federal health programs and private health programs. The information collected will be entered into a new system of records called the National Provider System (NPS), HHS/HCFA/OIS No. 09-70-0008. Institutional providers' data are protected by section 1106 of the Social Security Act and the Freedom of Information Act, while individually identifiable providers' data are protected by the Privacy Act of 1974.

Failure to provide complete and accurate information may cause the application to be returned and delay processing. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you furnished on the form. (See the instructions for completing the NPI application/update form to find the information that is voluntary or mandatory.)

Information may be disclosed under specific circumstances to:

1. The entity that contracts with HHS to perform the enumeration functions, and its agents, and the NPS for the purpose of uniquely identifying and assigning NPIs to providers.
2. Entities implementing or maintaining systems and data files necessary for compliance with standards promulgated to comply with title XI, part C, of the Social Security Act.
3. A congressional office, from the record of an individual, in response to an inquiry from the congressional office made at the request of that individual.
4. Another Federal agency for use in processing research and statistical data directly related to the administration of its programs.
5. The Department of Justice, to a court or other tribunal, or to another party before such tribunal, when
 - (a) HHS, or any component thereof, or
 - (b) Any HHS employee in his or her official capacity; or
 - (c) Any HHS employee in his or her individual capacity, where the Department of Justice (or HHS, where it is authorized to do so) has agreed to represent the employee; or
 - (d) The United States or any agency thereof where HHS determines that the litigation is likely to affect HHS or any of its componentsis party to litigation or has an interest in such litigation, and HHS determines that the use of such records by the Department of Justice, the tribunal, or the other party is relevant and necessary to the litigation and would help in the effective representation of the governmental party or interest, provided, however, that in each case HHS determines that such disclosure is compatible with the purpose for which the records were collected.
6. An individual or organization for a research, demonstration, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or for the purposes of determining, evaluating and/or assessing cost, effectiveness, and/or the quality of health care services provided.
7. An Agency contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system, or for developing, modifying and/or manipulating automated data processing (ADP) software. Data would also be disclosed to contractors incidental to consultation, programming, operation, user assistance, or maintenance for ADP or telecommunications systems containing or supporting records in the system.
8. An agency of a State Government, or established by State law, for purposes of determining, evaluating and/or assessing cost, effectiveness, and/or quality of health care services provided in the State.
9. Another Federal or State agency
 - (a) As necessary to enable such agency to fulfill a requirement of a Federal statute or regulation, or a State statute or regulation that implements a program funded in whole or in part with Federal funds.
 - (b) For the purpose of identifying health care providers for debt collection under the provisions of the Debt Collection Information Act of 1996 and the Balanced Budget Act.

INSTRUCTIONS FOR COMPLETING THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form.

This application is to be completed by, or on behalf of, a health care provider or a subpart seeking to obtain an NPI. (See 45 CFR 162.408 and 162.410 (a) (1).)

SECTION 1 – BASIC INFORMATION

This section is to identify the reason for submittal of this form and the type of entity seeking to obtain an NPI.

A. Reason for Submittal of this Form

This section identifies the reason the health care provider is submitting this form.

1. **Initial Application**

If applying for a NPI for the first time check box #1, and complete appropriate sections as indicated in Section 1B for your entity type.

2. **Change of Information**

If changing information, check box #2, write your NPI number in the space provided, and provide the new/changed information within the appropriate section. See the instructions in Section 4, then sign and date the certification statement in Section 4A or 4B. All changes must be reported to the NPI enumerator within 30 days of the change. It is not necessary to complete sections that are not being changed; however, please ensure that your NPI number is legible and correct. Complete Section 5 so that we may contact you in the event of problems processing this form.

3. **Deactivation**

Record the NPI number you want to deactivate and check box #3 indicating the reason. If you check Other, give reason; e.g., Fraudulent Use. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for section 4. Use additional sheets of paper if necessary.

B. Entity Type

Check the box that most applies to you or your organization. *(Required for initial applications)*

1. Individuals who render health care or furnish health care supplies to patients; e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists. Note that incorporated individuals may also obtain NPIs as type 2 organizations.
2. Organizations that render health care services, or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, health maintenance organizations, durable medical equipment suppliers, pharmacies.

SECTION 2 - IDENTIFYING INFORMATION

A. Individual

NOTE: An individual may obtain only one NPI, regardless of the number of taxonomies (specialties), licenses, or practice locations he/she may possess.

Name Information

- 1-6. Provide your full legal name. (Required first and last name) Do not use initials or abbreviations. If you furnish your social security number in block 19, this name must match the name on file with the Social Security Administration (SSA). In addition, the date of birth must match that on file with SSA. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

Other name information *(Use additional sheets of paper if necessary)*

- 7-12. If you have used another name, including a maiden name, supply that "Other Name" in this area. (Optional) You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.
13. Mark the check box to indicate the type of "Other Name" you used. (Required if 7-12 are completed)
- 14-16. Provide the date *(Required)*, State *(Required)*, and country *(Required, if other than U.S.)* of your birth. Do not use abbreviations other than United States (U.S.).
17. Indicate your gender. *(Required)*
18. Furnish your Social Security Number (SSN) for purposes of unique identification. *(Optional)* If you furnish your SSN, this name must match the name and date of birth on file with the Social Security Administration (SSA). If you do not furnish your SSN, processing of your application may be delayed because of the difficulty of verifying your identity via other means; you may also have difficulty establishing your proper identity with insurers from which you receive payments. If you are not eligible for an SSN, see item #19.
19. Furnish your IRS Individual Taxpayer Identification Number (ITIN) if you do not qualify for an SSN. *(Required, if the applicant has an ITIN)* You may not use an ITIN if you have an SSN. IRS issues ITINs to foreign nationals and others who have federal tax reporting or filing requirements and do not qualify for SSNs. Examples of individuals who need ITINs include:
- Non-resident alien filing a U.S. tax return and not eligible for an SSN;
 - U.S. resident alien *(based on days present in the United States)* filing a U.S. tax return and not eligible for an SSN;
 - Dependent or spouse of a U.S. citizen/resident alien; and
 - Dependent or spouse of a non-resident alien visa holder.

If you do not furnish your SSN or ITIN, you must furnish another proof of identity with this application form: a photocopy of your driver's license, State issued ID, employer ID, passport, or birth certificate.

B. Organizations and Groups

- 1-2. Provide your organization's or group's name *(legal business name used to file tax returns with the IRS)* and Employer Identification Number *(assigned by the IRS)* or Social Security Number (SSN). *(Required)*
3. If your organization or group uses or previously used another name, supply that "Other Name" in this area. *(Optional)* Use additional sheets of paper if necessary.
4. Mark the check box to indicate the type of "Other Name" used by your organization. *(D/B/A Name=Doing Business As Name.) (Required if 3 is completed.)*

SECTION 3 - ADDRESSES AND OTHER INFORMATION

A. Mailing Address Information

This information will assist us in contacting you with any questions we may have regarding your application for an NPI or with other information regarding NPI. You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise during our review of your application. You may also add an e-mail address. *(Required)*

B. Practice Location Information

Provide information on the address of your primary practice location. If you have more than one practice location, select one as the "primary" location. Do not furnish information about additional locations on additional sheets of paper. *(Required)*

C. Other Provider Identification Numbers *(Optional)*

Please list the provider identification number(s) you currently use. This would include Medicare-issued numbers (UPIN, NSC, OSCAR, and PIN numbers), Medicaid-issued number *(show State)*, and numbers issued by other health plans *(give a brief description of issuer)*. If you do not have such numbers, you are not required to obtain them in order to be assigned an NPI.

D. Provider Taxonomy Code *(Provider Type/Specialty) (Required)*

Provide your 10-digit taxonomy code. Information on taxonomy codes is available at www.wpc-edi.com/taxonomy. You may provide a written description instead in the space provided, and we will assign the closest appropriate code.

Furnish the provider's health care license or certificate number(s) (if applicable). If issued by a State, show the State that issued the license/certificate. The following individual practitioners are required to submit a license number *(If you are one of the following and do not have a license or certificate, you must enclose a letter to the Enumerator explaining why not)*:

Psychoanalyst	Clinical Psychologist	Chiropractor
Dentist	Optometrist	Licensed Nurse
Pharmacist	Nurse Practitioner	Physician Assistant
Clinical Nurse Specialist	Podiatrist	Certified Registered Nurse Anesthetist
Physician/Osteopath	Licensed Psychiatric Technician	Psychologist, Psychotherapy
Registered Nurse		

The following organizations are also required to submit a license number. Provide your license number(s) and State(s) where issued:

Home Health Agency	Hospital Unit	Hospital
Clinical Medical Laboratory	Managed Care Organization	Nursing Facility
Pharmacy	Federally Qualified Health Center	

You may use the same license or certificate number for multiple taxonomies; e.g., if you are a physician with several different specialties.

NOTE: A health care provider that is an organization, such as a hospital, may obtain an NPI for itself and for any subparts that it determines need to be assigned NPIs. In some cases, the subparts have Provider Taxonomy Codes that may be different from that of the hospital and of each other, and each subpart may require separate licensing by the State (e.g., General Acute Care Hospital and Psychiatric Unit). If the organization provider chooses to include these multiple Provider Taxonomy Codes in a request for a single NPI, and later determines that the subparts should have been assigned their own NPIs with their associated Provider Taxonomy Codes, the organization provider must delete from its NPS record any Provider Taxonomy Codes that belong to the subparts who will be obtaining their own NPIs. The organization provider must do this by initiating the Change of Information option on this form.

SECTION 4 - CERTIFICATION STATEMENT *(Required)*

This section is intended for the applicant to attest that he/she is aware of the requirements that must be met and maintained in order to obtain and retain an NPI. This section also requires the signature and date of signature of the "Individual" who is the type 1 provider, or the "Authorized Official" of the type 2 organization who can legally bind the provider to the laws and regulations relating to the NPI. See below to determine who within the provider qualifies as an Authorized Official. Review these requirements carefully.

Authorized Official's Information and Signature for the Organization

By his/her signature, the authorized official binds the provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied a National Provider Identifier if any requirements are not met. All signatures must be original. Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

An authorized official is an appointed official with the legal authority to make changes and/or updates to the provider's status (e.g., change of address, etc.) and to commit the provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider.

Only the authorized official(s) has the authority to sign the application on behalf of the provider.

By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.

SECTION 5 - CONTACT PERSON *(If the contact person is the same person identified in 2A or 4B, complete only item 8, E-mail Address.)*

To assist in the timely processing of the NPI application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. Please note that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 4 or the provider named in Section 2, as appropriate. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.