INMEDIATA
Services you trust for health.

CONFIGURATION FORM

PROVIDER INFORMATION					
Provider's Name			Group's Name		
Tax ID	NPI		ETIN	NPI	
Billing Address			Physical Address		
City	State	Zip Code	City	State	Zip Code
E-mail			Phone Number	Fax	

ADDITIONAL INFORMATION			
☐	Configure Biller	☐ Add Provider ☐ Eliminate Provider	☐ Biller's Tax ID:
☐	Configure Medical Group or Provider (s)	☐ Individual Account ☐ Virtual Account ☐ Eliminate Provider ☐ Group Organization Account	☐ Biller's Tax ID (Groups must complete page 2):
☐	Secure Track Username & Password	☐ Eliminate ☐ Add ☐ Change password ☐ Administrator	☐ Username:
☐	Secure Claim User	☐ Administrator ☐ Secretarial ☐ Biller ☐ Other:	☐ Name of user

AUTHORIZATION	
Biller	I,_____, authorize_____to undertake the billing of my electronic invoices.
Group	The group_____, authorizes that the physicians listed in this document be included in this account.

This document must contain in print the provider's name, authorized license or organization responsible for the account. All information submitted on this form is required to transmit electronically and reliably. For the record, I agree and complete this form according to the needs of my organization.

Please fax documents to 1(866)597-0277

Comments:

PROVIDER SIGNATURE	DATE

FOR INTERNAL USE	
Received by:	Date:
Processed by:	Date:
Digitalized by:	Date:

INMEDIATA
Services you trust for health.

Configuration Form

If you are a Medical Group, please complete this document, print name and identify the doctors of the group, their state license or UPIN number and NPI Number.

Healthcare Provider's Name	License Number or UPIN	NPI Number