INMEDIATA
Services you trust for health.

INSTALLATION FORM

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

SOFTWARE A INSTALAR		
	Program	**Quantity**
☐	IMPlug	
☐	Otro _____	

RE-INSTALATION		
☐	Software re-installation	Username: _____

AUTHORIZATION

I, _____, authorize Inmediata Health Group, to undertake installation of the detailed programs in this form.

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 ONLY	
Received by:	Date:
Processed by:	Date:
Digitalized by:	Date: