

Request Date:



NON-PARTICIPATING PROVIDER VERIFICATION FORM

In order to process your most recent authorization and/or claim, please complete and fax this form to Affinity at 718-536-3315 within three (3) days of receipt. In addition, please attach W9 form.

Provider Name _____

NPI# [grid] License# [grid]

Medicaid# [grid] Medicare# [grid]

Provider Type: (Check all that apply)

- Medical Specialty -list type:
Primary Care & Multi Specialties Centers
Free Standing Community Health Center
Covering Physician
Sub Specialty-list specialty type(s):
Hospital
Ancillary- list ancillary type(s):
Article 28

Provider Office Information (Main Office)

Table with fields: Office Name, Address, City, State and Zip, Office NPI, Phone Number, Fax Number, Contact Person & Title, Email Address

Provider Billing Information

Table with fields: Payee Name, Address, City, State and Zip, Tax ID Number, Phone Number, Fax Number, Contact Person & Title, Email Address

Completed by: X _____
Signature Print Name
Title Date

Internal Use Only
Affinity Provider # Effective Date

If you have more than one office and/or billing office, please complete the next page.

Provider Office Information *(Secondary Office)*

Office Name:										Address, City, State and Zip:									
Office NPI:																			
Phone Number:										Fax Number:									
Contact Person & Title:																			
Email Address:																			

Provider Billing Information

Payee Name:										Address, City, State and Zip:									
Tax ID Number:																			
Phone Number:										Fax Number:									
Contact Person & Title:																			
Email Address:																			

Provider Office Information *(Additional Office)*

Office Name:										Address, City, State and Zip:									
Office NPI:																			
Phone Number:										Fax Number:									
Contact Person & Title:																			
Email Address:																			

Provider Billing Information

Payee Name:										Address, City, State and Zip:									
Tax ID Number:																			
Phone Number:										Fax Number:									
Contact Person & Title:																			
Email Address:																			