PAERS PROVIDER ADD FORM

BRANDS	☐ HIP ☐GHIHMO ☐ GHIPPO
GROUP NAME	
TIN	
PROVIDER LAST NAME	
PROVIDER FIRST NAME / MIDDLE INITIAL	
EFFECTIVE DATE	
SSN	
GENDER	
DATE OF BIRTH	
DEGREE	
DEA NUMBER / EXPIRATION DATE	/
MEDICARE ID	
NYS MEDICAID ID	N/A
OFFICE HOURS	
STATE OF LICENSE/LICENSE NUMBER	/
EXP DATE	
NPI NUMBER	
SPECIALITY	
BOARD CERTIFICATION	
PRACTICE ADDRESS	
CITY, STATE ZIP	
PHONE NUMBER	
FAX NUMBER	
BILLING NAME	
BILLING ADDRESS	
CITY, STATE ZIP	
HOSPITAL AFFILIATION	

This form must be submitted with contract signature page and the group W9