Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

0 1 1 3

Group Membership Authorization

Providers who will be submitting Medicaid claims under a group number must indicate the group's Medicaid provider number and the date they first joined the group to authorize the group to bill on their behalf. NOTE: If the date the provider joined the group is earlier than the date the provider and the group were both effective with Medicaid, the group link will be effective with the later date.

If the group application is pending, list the group's name instead of their Medicaid provider number so this form may be matched to the group's pending application.

Provider Name: _____
(Please print)

Group Name: *(Required only if group's provider number is pending)*	**Group Tax ID:** *(Required only if group's provider number is pending)*	**Group Medicaid Provider ID:** *(Leave blank if pending)*	**Effective Date:**

"I authorize the group providers listed above to submit claims for services performed by myself. I understand that, by making this request, all disbursements made for services performed by myself under these groups will be made directly to them on my behalf."

_____ _____
(Signature of Provider) Date