NDMS Definitive Care Reimbursement Program  
Provider Registration Form¹

### PART I. PROVIDER CONTACT INFORMATION

1. Name of Business or Individual:

2. Doing Business As (D/B/A):

3. Tax Identification Number:²  
   3a. Social Security Number (SSN):
   3b. Federal Employer Identifier Number (FEIN):

4. Physical Street Address:  
   4a. Building, Suite Number: (or P. O. Box if applicable)

5. Contact Person:³  
   5a. Contact Person's Phone #:
   5b. Contact Person's Fax #:
   6c. Contact Person’s E-mail Address:

### PART II. PROVIDER TYPE

7. Provider Type Code:  
8. Practice Type Code:  
9. Category of Service Code:

10. NPI Number:  
11. Medicaid Number:  
12. Medicare Number:

13. E-mail Address for Remittance Advice:  
14. Mailing Address for Remittance Advice: (leave blank if e-copy is sufficient)
   City:  
   State:  
   ZIP:

### PART III. AUTHORIZATION

By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. All arrangements between the Financial Institution and the said Provider or Supplier are in accordance with all applicable regulations and instructions with the effective date of the EFT authorization. You must notify Federal Fiduciary regarding any changes in the account in sufficient time to allow Federal Fiduciary to act on the changes.

<table>
<thead>
<tr>
<th>Authorized/Delegated Official Name (Print)</th>
<th>Authorized/Delegated Official Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized/Delegated Official Title</td>
<td>Authorized/Delegated Official E-mail Address</td>
</tr>
<tr>
<td>Authorized/Delegated Official Signature (Note: Must be original signature in black or blue ink.)</td>
<td>Date</td>
</tr>
</tbody>
</table>

¹ Any person or entity that wants to be paid for rendering inpatient hospital services to victims of the Haiti earthquake must complete this form. Please type or print in blue or black ink. Do not use red ink. If you are having problems completing the form, please use the Step by step instructions found in the Instructions for Completing a Provider Enrollment Form.

² Enter either the SSN or FEIN by which the IRS knows you. The Tax ID you enter here is what will be reported to the IRS as required by law. If you are individually incorporated, list your FEIN and not your SSN. Do not enter both.

³ List the person who Federal Fiduciary should contact if there are questions about the enrollment form.