



EXAMPLE ONLY

Request for Addition / Deletion to Existing Assignment Account

**** Note:** For additional practice addresses or address changes, complete "Change of Address Form".
For NaviNet users, address changes can be made online.

Name of account VA Pittsburgh Healthcare System

Group account number (MCCR)

IRS number 251723912

Type 2 (Group) National Provider Identifier (NPI) 1811947815

Main Practice Address** University Drive C
Pittsburgh, PA 15240

Specialty Acute Care Hospital

Effective date of change _____

Telephone number (412) 822-1070

Member Access Number (Patients can call this number to make an appointment for this location): () _____

Fax number (412) 822-1109

Provider name (Typed or printed)	CAQH ID	Social Security Number	Type 1 (Individual) NPI	Provider signature (Required for additions)	Provider specialty (For Additions)	Indicate	
						Add ①	Delete ②
<u>Doe, John</u>		<u>000-11-2222</u>	<u>1245567</u>	<u>John Doe</u>	<u>Radiology</u>	<u>①</u>	
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

- ① By my signature, I, as a member of this account, fully agree to abide by the requirements listed on the reverse side of this form.
- ② Deletions - Please provide the following information for providers being deleted from the assignment account:

Provider name (Typed or printed)	Provider number	New address	New telephone number
_____	_____	_____	() _____
_____	_____	_____	() _____

Mail to: **Provider Information Management**
PO Box 898842
Camp Hill, PA 17089-8842

Fax to: (800) 236-8641

EXAMPLE ONLY

Application for an Individual VA Professional Provider Number for Billing

Directions: Please fill out and attach this form to the Authorization for Billing (AFB) when adding a provider to your Professional Group. This would only be used for those providers who do not already have billing privileges with Highmark.

Complete the following information pertaining to the Assignment Account

VA Pittsburgh Healthcare System
Assignment Account Name _____ Assignment Account Number (MCCR) _____
University Drive C 251-723-912 1811947815
Location (PO Box will not be accepted) IRS ID # _____ Group NPI _____
Pittsburgh, PA 15240 (412) 822-1070
City, State and Zip Code Office Telephone Number

Complete the following information on the provider being added to this Assignment Account

DOE JOHN MD
Provider's Last Name Provider's First Name Degree
1243367 RADIOLOGY MD 4444E PA 12/31/2012
Provider's NPI Provider's Specialty Medical License # State Exp. Date
PITTSBURGH PA 15235 (412) 111-2222
City, State and Zip Code Office Telephone Number

Does this practitioner currently practice at another location? Yes No

PAK one

IMPORTANT

When presenting this form with the intent of adding the above named provider to the above listed Assignment Account, you are agreeing to the stipulations set forth within the Memorandum of Understanding agreed upon with Highmark for billing standards and allowances. This provider will be issued a billing number under his/her individual name and will be shown as associated with your group.

This number will only be valid for the purpose of billing as a professional provider rendering services at your Veteran's Administration Facility. Please ensure that we are informed promptly once a provider is no longer associated with your facility.

The signature of an authorized representative is required to process this request.

Authorized Representative's Signature
(Manager, Patient Accounts)

Date



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						Add ①	Delete ②
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

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University Drive C _____ 251-723-912 1811947815
Location (PO Box will not be accepted) _____ IRS ID # _____ Group NPI _____
Pittsburgh, PA 15240 _____ (412) 822-1070
City, State and Zip Code _____ Office Telephone Number _____

Complete the following information on the provider being added to this Assignment Account

Provider's Last Name _____ Provider's First Name _____ Degree _____
Provider's NPI _____ Provider's Specialty _____ Medical License # _____ State _____ Exp. Date _____
City, State and Zip Code _____ (_____) _____ Office Telephone Number _____

Does this practitioner currently practice at another location? Yes No

IMPORTANT

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