Portal Enrollment Form

PRACTICE INFO:	
Enrollment Date:	
Practice Name:	Website:
Contact Person/Title:	Phone #:
Email:	
Specialty:	
Owner of Practice:	
Street Address:	
City:	
State:	
Zip:	
If you have an EHR, which vendor do you use:	
Estimated number of patients in practice (active or inactive):	
Estimated number of patients seen monthly:	
Top 3 Payers (Carrier and percentage-include Medicare):	
1.	
2.	
3.	
PROVIDER INFO: *If >2 attach list*	
PROVIDER NAME:	
NPI:	
Specialty:	
PROVIDER NAME:	
NPI:	
Specialty:	
LIST OF USERS/ROLES *Indicate if Provider or Staff Member for role-based credentials*	
Name/Role:	
Name/Role:	
Name/Role:	
Name/Role:	
Name/Role:	
Name/Role:	