SMG Mediquip, LLC
P.O. Box 736
Bethpage, NY 11714-0736
516.586.4934 (phone)
800.717.2573 (fax)
800.211.0404 (fax)
www.smgmediquip.net

PHYSICIAN PROGRAM ENROLLMENT FORM

Please complete and fax back to us at the number above. Thank you!

Physician Name(s): ____

Name of Practice: ____

Address: ____

Phone: ______________________________ Fax: __________________________

E-Mail: ______________________________________ NPI: __________________

Office Manager/Contact: ____

Indicate preferred method of contact:

____ Phone ____ E-mail (Address: ____________________________________)

We request that initial payment of third party insurance benefits be made on behalf of our authorized patients to SMG Mediquip, LLC for any equipment or services furnished to patients by us.

We authorize any holder of medical information about our authorized patients to release to the Health Care Financing Administration and its agent, or to any respective third party insurance carrier, any information needed to determine these benefits payable for related services.

We permit a copy of this authorization to be used in place of the original.

Form 1099 Information:

Please indicate whether you would like fitting/administrative checks made payable to:

____ Doctor ____ Practice

Tax ID # for payee: ____

Signature: ______________________________ **Date**: ________________