

\* Incomplete or illegible forms will cause a delay in processing and will be returned.

<b><u>Practice Information</u></b>	
Please type or print clearly	
Group/Provider Name:	
Provider Address:	
City, State, Zip:	
Phone Number:	
Fax Number:	
Email:	
Contact Name:	
Tax ID:	
VAR Name:	
VAR Contact: Diane Wallace	
VAR Email: mbccinc@aol.com	

<b><u>Billing Service Information</u></b>	
*If applicable	
B/S Name:	
B/S Address:	
City, State, Zip	
B/S Contact:	
B/S Phone:	
B/S Email:	
B/S Tax ID :	

<b><u>Practice Management System</u></b>	
MediSoft: <input checked="" type="checkbox"/>	Lytec: <input type="checkbox"/>
<b><u>Current EDI Service Type</u></b>	
New MSLC Client:	<input type="checkbox"/>
Existing Medavant:	<input type="checkbox"/> Client ID:
Other Clearinghouse:	<input type="checkbox"/>
<b><u>Communication Method</u></b>	
Broadband: <input checked="" type="checkbox"/>	Dial Up: <input type="checkbox"/>

<b><u>Registration Information</u></b>	
Vendor ID: 200722	
Billing ID:	
Submitter ID:	

<b><u>Provider Names (First &amp; Last)</u></b>	

<b><u>Transaction Type</u></b>	
<input checked="" type="checkbox"/> Flat Fee (Per Provider)	<input type="checkbox"/> Per Transaction Services
(Please choose a la carte or bundled option)	
<input type="checkbox"/> A La Carte Flat Fee Services – select transaction type(s)	
<input type="checkbox"/> Electronic Claims	
<input type="checkbox"/> Electronic Remittance	
<input type="checkbox"/> Eligibility Verification	
<input checked="" type="checkbox"/> EDI Bundled Services (includes Claims, ERA & Eligibility)	

<b><u>Internal Use Only</u></b>	
Super User ID:	Sales Associate Initials:
Password:	Date:                      Medal:
Enrollment/Registration ID:	RelayHealth Submission Date:
	RelayHealth Confirmation Date:
	MSLC Date Received:              Completed By: