For Nurse Registries Only

Please fill-out completely, where applicable: Print legibly

Facility Information:

1. Name: _____
2. Telephone: _____
3. Fax: _____
4. Email, if applicable: _____
5. Medicaid Provider No.: _____
6. NPI No.: _____
7. EIN No. (Tax ID): _____

Owner

Name: _____

Phone: _____ Email:_____

Managed Care Organization

1.Name of Managed Care: _____

User Id Login: _____

Password: _____

ATTACH VOIDED CHECK for electronic payment

Notes:

_____

_____

_____ _____

Authorized Signature **Date**

Return completed form to office@arrendells.com