National Provider Identifier (NPI) Number Form
Provider Organization

SAN FRANCISCO HEALTH PLAN
Here for you

Submit this form *with IRS W-9* to San Francisco Health Plan, Provider Relations Department:
Fax: (415) 615-6450 or Mail: P.O. Box 194247, San Francisco, CA 94119
Questions: Call 415-547-7818 ext. 7084 or E-mail: Provider.Relations@sfhp.org

The information provided on this form is to be used to process claims submitted to San Francisco Health Plan, as well as any correspondence sent to our office. Please keep in mind that this form is not a contract.

Please complete the following information.

PROVIDER NAME:	Legal Name:
	DBA Name, if used:
BILLING NPI: (The NPI used in *CMS-1500* form box 33a, or *UB-04* form box 56)	NPI:
TAX ID:	Tax ID: Important: please submit an IRS W-9 with this form. We need both to complete your claims setup.
OFFICE CONTACT:	Name: Phone: e-mail: Fax:
PRIMARY/PHYSICAL ADDRESS: (Attach a separate form for additional office locations)	Street: Suite: City: State: ZIP: Phone: Fax:
MAILING / BILLING ADDRESS: (Remittance advice will be sent to this address)	Street: Suite: City: State: ZIP: Phone: Fax:

To avoid delay in processing of claims and correspondence, please ensure that all requested documentation are submitted timely. Please allow five business days for the completion of your information.

Person completing this form: Date: