MDLand®

Your Companion to
Electronic Medical Practice

Electronic Claim Enrollment Form

Please fax the completed form back to MDLAND at (212) 937-3158 OR e-mail the form to support@mdland.com

Provider Information

Group/Facility Name					
Provider Name		**Contact Name**			
Provider Address					
City		**State**		**Zip**	
Provider Telephone		**Provider Fax**			
Provider SSN/Tax ID					

INSURANCE (PAYER) REQUESTED (see payer list at http://www.mdland.com/support**)**

	Insurance (Payer) Name	Payer ID	Individual Provider ID*	Group ID	Billing NPI ID	Group
1						☐
2						☐
3						☐
4						☐
5						☐
6						☐
7						☐
8						☐
9						☐
10						☐

Please include your e-mail address here (requested in order to process this form). Thank you!

15 East 32nd Street, 2nd Floor
New York City, NY 10016

PHONE 212.363.8000
FAX 212.937.3158