Preferred Care
EDI Enrollment Form
Attention: EDI Coordinator
Fax 585.258.8071

Please Select One:

*Clearinghouse:______________________________ Billing Service:______________________________

Practice/Facility Information

*Name of Practice:____

*Street Address:____

*City:____

*State:_______*Zip Code:_________*Telephone:____________________Fax:__________________________

*Person to Contact:_______________________________________Title:_________________________________

*Practice Tax ID:_____________________________Type of Practice: Group_____ Solo_______(Check one)

*Email Address:____

Provider/Facility Information:

*Name and Title of Provider

____NPI_______________________________________

____NPI_______________________________________

____NPI_______________________________________

____NPI_______________________________________

____NPI_______________________________________

____NPI_______________________________________

Technical Information

*Software Vendor:____

*Contact Name & Phone Number:____

*Contact Email Address:____

Access ID:____

*HIPPA Transaction Types (Check all that apply)

837I________837P________835_________

**** Required Field***