MEDICAL MUTUAL®

Provider Information Form

This form is imaged. Please print with black ink or fill in using Acrobat® Reader®.
Please use additional forms for each Federal Tax Identification Number (TIN).

Page _____ of _____
Info Effective Date _____

Check One: ❑ Add ❑ Delete

Check One: ❑ PCP ❑ Specialist ❑ Hospitalist ❑ Group ❑ Urgent COVID19 Provider ❑ Hospital/Institutional ❑ Locum Tenen ❑ Hospital Based ❑ Floater/Covering Provider ❑ Telemedicine

Identification Information (Professional Providers Only)

NPI No.	Social Security No.	Last Name	First Name	M.I.	Title (M.D., etc.)

Primary Specialty	Secondary Specialty

If deleting a PCP, move members to	Accepting New Patients ❑ Yes ❑ No	CAQH Number	Date of Birth

Service Location Information

TIN	Facility or Group Name

Street Address	City	State	Zip + 4	County

Appointment Phone	Fax	Specialty	NPI No.

Correspondence Street Address, City, State & Zip — Fill in here or use same as: ❑ Remittance Address ❑ Service Location

Additional Service Location

Facility or Group Name, if different than above

Street Address	City	State	Zip + 4	County

Appointment Phone	Fax	Specialty	NPI No.

Additional Service Location (Please complete another form for any additional locations.)

Facility or Group Name, if different than above

Street Address	City	State	Zip + 4	County

Appointment Phone	Fax	Specialty	NPI No.

Remittance Address Information — Substitute form for W-9

Reimbursement Name (Legal Name on W-9)	Reimbursement Entity's TIN.

Type of Entity (Please check) ❑ Individual / Sole Proprietor ❑ Corporation ❑ Partnership ❑ Other

I certify under penalty of perjury that the Tax Identification Number I have provided is correct.

Signature	Date

Street Address / P. O. Box

City	State	Zip + 4	Phone	Fax

Additional comments/reason for submitting form — ❑ Check here if provider credentialing needed

Office Manager or Administrator	Phone	E-mail Address	Today's Date

Contract ID (INTERNAL USE ONLY)

Traditional	Commercial	Tier	DenteMax

Contract Entity Name

Provider Information Form Instructions

1. This form must be completed when changing, adding or modifying any provider information as requested on this form. Providers who wish to apply for the SuperMed® network should contact their Provider Contracting representative for the appropriate forms. Please see section 6 below for a listing of the SuperMed network Provider Contracting Offices

2. Please fill out the form completely and legibly. Incomplete forms will be returned unprocessed.

3. Please complete one form per transaction. For example, if you are moving from one location to another, complete one form to "add" the new address and complete another form to "delete" the old address location.

4. **Ancillary and institutional providers, except ambulance and diagnostic laboratory providers:** When adding a new office or a facility location, visit Provider.MedMutual.com, Credentialing, Credentialing Applications to submit the required credentialing application. **For all other ancillary inquiries:** please contact (877) 271-4093.

5. If you are closing your practice to new members (or reopening a closed practice), please complete the form and mark the correct "yes" or "no" box in the field marked "Accepting New Patients."

6. Please return completed forms to your appropriate regional office.

Provider Contracting Offices

Northeast Ohio
(Cleveland Office)
MZ: 01-5B-3850
2060 East Ninth Street
Cleveland, OH 44115-1355
Fax: (216) 687-7994
Phone: (800) 625-2583

Northwest Ohio
(Toledo Office)
MZ: 25-3845
9848 Olde Highway US 20
Rossford, OH 43460-1722
Fax: (419) 595-6200
Phone: (888) 258-3482

Central/Southeast Ohio
(Columbus Office)
MZ: 09-7502
One Columbus
10 West Broad Street, Suite 1400
Columbus, OH 43215-3469
Fax: (614) 621-4578
Phone: (800) 235-4026

Southwest Ohio
(Cincinnati Office)
MZ: 05-7502
300 E. Business Way, Suite 100
Cincinnati, OH 45241-2369
Fax: (513) 684-8121
Phone: (800) 589-2583

If you are not sure which Provider Contracting office to call, visit Provider.MedMutual.com, Contact Us to determine which regional office supports your county.

7. For large groups interested in submitting this information electronically, please contact your Provider Contracting Representative for file specifications.