ENROLLMENT FORM

PLEASE FILL IN THE INFORMATION BELOW FOR THE PERSON OR ENTITY RESPONSIBLE FOR CHARGES AND MAINTAINS OWNERSHIP AND ACCESS TO THE ACCOUNT.

Owner of Account/Practice Name:* _____

*Please Note: If this is a billing service, clearinghouse, or software vendor please enroll as such. You may enter provider information below.

OFFICE INFORMATION

Mailing Address:

Street Address:*_____

City: *_____ State: * _____ Zip: * _____

Contact Information: (Individual actually submitting claims)

First Name:*_____ Last Name:*_____

Telephone: *_____ Facsimile: *_____

Email: *_____ Title:* _____

Type of Practice:*

☐ Billing Company ☐ Solo Practice ☐ Group Practice ☐ Clearinghouse ☐ Software Vendor

Are you a member of ActivHealthCare? ☐ Yes ☐ No **The Payer ID for ActivHealthCare claims is AHCØ1.**

BILLING INFORMATION

Billing Address: ☐ Check if same as mailing address

Street Address:*_____

City: *_____ State: * _____ Zip: * _____

Billing Contact Information: ☐ Check if same as contact information in previous section

First Name:*_____ Last Name:*_____

Telephone: *_____ Facsimile: *_____

Email: *_____ Title:* _____

PROVIDER/GROUP INFORMATION

If you are enrolling as a Group complete the "Group Provider(s)" section and if any individual providers are billing under the Group NPI# then list them in the "Individual Provider(s)" section. If you are enrolling as an individual provider complete the "Individual Provider(s) section. If you need room for additional providers then print another copy of this page and submit with enrollment form.

Group Provider(s)

1	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
2	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
3	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
4	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____
5	Name of Billing Provider/Group: *_____ Tax ID: *_____ Group NPI#:* _____ Specialty: *_____

Individual Provider(s)

1	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
2	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
3	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
4	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty: *_____
5	First Name: *_____ Last Name:* _____ Tax ID: *_____ Individual NPI#:* _____ Specialty:*_____

SYSTEM INFORMATION*

Please tell us how you would like to submit your claims. Check ALL that apply (must select at least one)

- ☐ Undecided
- ☐ Office Ally's Practice Mate
- ☐ Office Ally's Electronic Health Records System
- ☐ Office Ally's Online Claim Entry Tool

  Forms Used: ☐ CMS 1500 ☐ UB-04 ☐ ADA
- ☐ We will be using another billing software (Please include your software information below)

  Software/Version: _____

CREDIT CARD PROCESSING UTILITY

☐ Yes, I am interested in Office Ally's integrated credit card processing. Please contact me with additional information.

Best Time to Contact: _____ Best Contact Method: _____ Promo Code: _____

Special Instruction/Alternate Contact: _____

BILLING COMPANY

☐ Yes, I am interested in Office Ally's Billing Service. Please contact me with additional information.

Best Time to Contact: _____ Best Contact Method: _____

OFFICE ALLY REPRESENTATIVE*

Please list your Office Ally Representative: _____

How did you hear about us? _____

ONEHEALTH PORT USERS

Currently enrolled OneHealth Port users check the box below, and fill in your OneHealth Port User Name.

Are you a OneHealth Port user? ☐ Yes ☐ No OneHealth Port User Name: _____

**This will become your Office Ally User Name if available*

In order to process your enrollment you must also submit a one (1) page Authorization sheet included with this form. Within 24 hours of receiving your enrollment form and authorization sheet you will receive an email containing your username and a link to create your password. Within 24 hours after this an Office Ally representative will contact you to schedule a training appointment.