PROMOTING INTEROPERABILITY PROGRAM

PROVIDER MASTER FILE AUTHORIZATION FORM (PMF)
PROMOTING INTEROPERABILITY PROGRAM

Please complete all sections

Type of Modification: □ To Add to PMF □ To Add Corporation/Group □ To Correct Address

Provider's Full Name (Including both last names):		
Provider's Postal Address: **City:**	**State: PR**	**Zip Code:**
Provider's Primary Practice Physical Address: **City:**	**State: PR**	**Zip Code:**
Provider NPI Number:	**Provider Tax ID Number (SS#):**	
Providers Specialty:	**Medical License #**	
Providers Email Address:		

Please complete this section <u>ONLY</u> IF PAYEE is a Corporation or Group

Payee Name (Corporation/Group Legal Name):	
Payee NPI Number (For Corporation/Group):	**Payee Tax ID Number for Corporation/Group)** **660-**
Payee Mailing Address (Where Annual Tax Documents Form 480 will be sent:) **City/State/Zip:**	

Authorized signature: If submitting the form for a provider, the provider must sign below. If submitting this form for a group, business or institution, the authorized representative may sign below:

I hereby certify that the information above is true and correct

Provider Signature:	Date: (MM \ DD \ YYYY)
Printed Name of Person Submitting:	Title of Person Submitting Form

After completing and signing this certification please email to mppipr@asespr.org.
For any questions, please call 787-474-3300 Ask for MPIP Office