

**PROVIDER IDENTIFICATION MATRIX**

Clinic Name: \_\_\_\_\_ Check writing address (if different)  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ City: \_\_\_\_\_  
 County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ FAX # ( ) \_\_\_\_\_

Physician/Supplier Name: \_\_\_\_\_  
 Physicians only: Sole Practice \_\_\_\_\_ Group Practice \_\_\_\_\_ (Please check one)

Billing Service: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ FAX# ( ) \_\_\_\_\_

**\*\*\*PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO GIVE US CORRECT #'S AND COORDINATE CHANGES WITH PAYORS\*\*\***

ET&T Acct#: _____	FOR USE BY ET&T ONLY		
	Forms to payor	Ready to transmit	Comments
Medicare ID: _____	_____	_____	
Upin: _____ Pin: _____	_____	_____	
Medicaid ID: _____	_____	_____	
Pin: _____	_____	_____	
BC/BS: _____	_____	_____	
Pin: _____	_____	_____	
Champus/VA: _____	_____	_____	
R.R. Medicare: _____	_____	_____	
EIN/Tax ID#: _____	_____	_____	
SSN: _____	_____	_____	

Other:  
 Payor Name: \_\_\_\_\_ ID# \_\_\_\_\_ If more than three - please attach list.  
 Payor Name: \_\_\_\_\_ ID# \_\_\_\_\_  
 Payor Name: \_\_\_\_\_ ID# \_\_\_\_\_

**OTHER INFORMATION:**  
 Provider Specialty: \_\_\_\_\_ Specialty Lic #: \_\_\_\_\_ State Lic #: \_\_\_\_\_  
 CLIA #: \_\_\_\_\_ Dentist Lic. #: \_\_\_\_\_ Anesthesia Lic #: \_\_\_\_\_

Your printer type(please check one): Dot Matrix \_\_\_\_\_ Laser \_\_\_\_\_ Ink Jet \_\_\_\_\_

Box 27: Medicare Participating Provider Assignment Y or N (Circle one)

DO YOU WANT ET&T TO PRINT YOUR PAPER CLAIMS : Y or N (circle one)

**Billing Services: There is a \$10.00 paperwork fee each doctor: Check enclosed: \_\_\_\_\_ Charge my account \_\_\_\_\_**  
 (Fee waived for first year)

**PLEASE FAX COMPLETE MATRIX FOR EACH DOCTOR TO AUTOMATES**  
**949-203-2849**