Form Approved
OMB No. 0938-0931

# NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form.

## SECTION 1 - BASIC INFORMATION

### A. Reason For Submittal Of This Form (Check the appropriate box)

1. ☐ Initial Application
2. ☐ Change of Information (See Instructions)
   NPI No. _____
3. Deactivation NPI No. _____
   REASON (Check one of the following)
   ☐ Death ☐ Business Dissolved
   ☐ Other: _____

### B. Entity Type (Check the appropriate box)

1. ☐ An individual who renders health care. (Complete Sections 2A, 3, 4A, and 5)
2. ☐ An organization that renders health care. (Complete Sections 2B, 3, 4B and 5)

## SECTION 2 - IDENTIFYING INFORMATION

### A. Individuals

| 1. Prefix (e.g.,Major, Mrs.) | 2. First | 3. Middle | 4. Last |
|---|---|---|---|
| 5. Suffix (e.g., Jr., Sr.) | | 6. Credential (e.g., M.D., D.O.) | |

Other Name Information (If applicable. Use additional sheets of paper if necessary)

| 7. Prefix (e.g.,Major, Mrs.) | 8. First | 9. Middle | 10. Last |
|---|---|---|---|
| 11. Suffix (e.g., Jr., Sr.) | | 12. Credential (e.g., M.D., D.O.) | |

13. Type of other Name
☐ Former Name ☐ Professional Name ☐ Other (Describe) _____

| 14. Date of Birth (mm/dd/yyyy) | 15. State of Birth (U.S. only) | 16. Country of Birth (If other than U.S.) |
|---|---|---|

17. Gender
☐ Male ☐ Female

| 18. Social Security Number (SSN) | 19. IRS Individual Taxpayer Identification Number |
|---|---|

### B. Organizations and Groups

| 1. Name (Legal Business Name) | 2. Employer Identification Number (EIN) or SSN |
|---|---|

3. Other Name (Use additional sheets of paper if necessary)

4. Type of Other Name
☐ Former Legal Business Name ☐ D/B/A Name ☐ Other (Describe) _____

## SECTION 3 - ADDRESSES AND OTHER INFORMATION

### A. Mailing Address Information

1. Mailing Address Line 1 (Street Number and Name or P.O. Box)

2. Mailing Address Line 2 (Address Information; e.g., Suite Number)

| 3. City | 4. State | 5. ZIP+4 or Foreign Postal Code |
|---|---|---|

6. Country Name (if outside U.S.)

| 7. Telephone Number (Include Area Code & Extension) | 8. Fax Number (Include Area Code) |
|---|---|

### B. Practice Location Information

1. Primary Practice Location Address Line 1 (Street Number and Name - P.O. Boxes Not Acceptable)

2. Primary Practice Location Address Line 2 (Address Information; e.g., Suite Number)

| 3. City | 4. State | 5. ZIP+4 or Foreign Postal Code |
|---|---|---|

6. Country Name (if outside U.S.)

| 7. Telephone Number (Include Area Code & Extension) | 8. Fax Number (Include Area Code) |
|---|---|

### C. Other Provider Identification Numbers (Use additional sheets of paper if necessary)

| Number Type | Number | **State (if applicable)** | **Issuer (Other type)** |
|---|---|---|---|
| UPIN | | | |
| Medicare | | | |
| Medicaid | | | |
| Other | | | |
| Other | | | |

### D. Provider Taxonomy Code (Provider Type/Specialty. Enter one or more codes) and License Number Information

Information on provider taxonomy codes is available at www.wpc-edi.com/taxonomy. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity.

1. Primary Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor , pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

| 2. License Number | 3. State where issued |
|---|---|

4. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

| 5. License Number | 6. State where issued |
|---|---|

7. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

| 8. License Number | 9. State where issued |
|---|---|

PENALTIES FOR FALSIFYING INFORMATION ON THE
NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

## SECTION 4 - CERTIFICATION STATEMENT

I, the undersigned, certify to the following:

- This form is being completed by, or on behalf of, a health care provider as defined at 45 CFR 160.103.
- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.
- I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.
- I have read and understand the Penalties for Falsifying Information on the NPI Application/Update Form as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.

### A. Individual Practitioner's Signature

| 1. Applicant's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) | 2. Date (mm/dd/yyyy) |
|---|---|
| | |

### B. Authorized Official's Information and Signature for the Organization

| 1. Prefix (e.g.,Major, Mrs.) | 2. First | 3. Middle | 4. Last |
|---|---|---|---|
| | | | |

| 5. Suffix (e.g., Jr., Sr.) | 6. Credential (e.g., M.D., D.O.) |
|---|---|
| | |

| 7. Title/Position | 8. Telephone Number (Area Code & Extension) |
|---|---|
| | |

| 9. Authorized Official's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.) | 10. Date (mm/dd/yyyy) |
|---|---|
| | |

## SECTION 5 - CONTACT PERSON

### A. Contact Person's Information

Check here if you are the same person identified in 2A or 4B.
If you checked the box, complete only item 8, e-mail address in this section (Section 5).

| 1. Prefix (e.g.,Major, Mrs.) | 2. First | 3. Middle | 4. Last |
|---|---|---|---|
| | | | |

| 5. Suffix (e.g., Jr., Sr.) | 6. Credential (e.g., M.D., D.O.) |
|---|---|
| | |

| 7. Title/Position | 8. E-Mail Address | 9. Telephone Number |
|---|---|---|
| | | |

**For the most efficient and fast receipt of your NPI, please use the web-based NPI process at the following address: https://nppes.cms.hhs.gov.NPI web is a quick and easy way for you to get your NPI.**

Or send the completed application to: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059