



Your Companion to
Electronic Medical Practice



ERA Enrollment Form

Please fax the completed form back to MDLAND at (212) 937-3158 OR e-mail the form to support@mdland.com

Provider Information

Group/Facility Name					
Provider Name			Contact Name		
Provider Address					
City		State		Zip	
Provider Telephone			Provider Fax		
Provider SSN/Tax ID					

INSURANCE (PAYER) REQUESTED (see payer list at <http://www.mdland.com/support>)

	Insurance (Payer) Name	Payer ID	Individual Provider ID*	Group ID	Billing NPI ID	Group
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Please include your e-mail address here (requested in order to process this form). Thank you!