

Electronic Claim Submission Enrollment Form

Practice Name: \_\_\_\_\_

Practice Tax ID #: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Clearinghouse Name: \_\_\_\_\_

Date of File Submission: \_\_\_\_\_

Claim Type:  UB04  HCFA1500

**Fax to: (850)383-3310**

**Attention: Network Services**

