

Use this form to add a provider to your account (*after the completion of your initial Apex Installation*). By signing this form I accept the terms and conditions as outlined in the Apex Service Agreement and authorize Apex to charge a \$50.00 enrollment fee for each additional provider listed below (billing services need not acquire provider signatures).

Additional Provider Information	
*Apex Client ID (all applicable):	*Are you a billing service? Yes No
*Doctor or Provider of Services Name:	
*Company Name (to be used on claims):	
Profession: Medical Dental Other	
*Specialty: Tax	konomy Code (if known):
Contact Name: *E	-mail:
Telephone #: Fax	ς #:
*Address (for payment of claims):	
5	ST: *Zip:
*Tax ID #: *Is th	<i>is your</i> Fed. ID # <i>or</i> Soc. Security #
*License #:	
*Individual NPI #: **Gro	up NPI#
If this doctor will be paying for his/her claims separate from the existing doctor(s) please fax a voided check	
to (801)642-0333 or provide the credit card number here:	exp
Provider/Authorized Signature:	
Additional Provider Information	
Additional Provide	r Information
Additional Provide *Apex Client ID (all applicable):	r Information *Are you a billing service? Yes No
*Apex Client ID (all applicable):	
*Apex Client ID (all applicable): *Doctor or Provider of Services Name:	
*Apex Client ID (all applicable):*Doctor or Provider of Services Name:*Company Name (to be used on claims):Profession: Medical Dental Other	
*Apex Client ID (all applicable):*Doctor or Provider of Services Name:*Company Name (to be used on claims):Profession: Medical Dental OtherSpecialty:Ta	*Are you a billing service? Yes No
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E	*Are you a billing service? Yes No xonomy Code (if known):
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E	*Are you a billing service? Yes No xonomy Code (if known): -mail:
*Apex Client ID (all applicable): *Doctor or Provider of Services Name: *Company Name (to be used on claims): Profession: Medical Dental Other Specialty: Contact Name: Ta Contact Name: Telephone #: Fa *Address (for payment of claims):	*Are you a billing service? Yes No xonomy Code (if known): -mail:
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E         Telephone #:       Fa         *Address (for payment of claims):       *	*Are you a billing service? Yes No xonomy Code (if known): -mail: x #:
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E         Telephone #:       Fa         *Address (for payment of claims):       *	*Are you a billing service? Yes No xonomy Code (if known): -mail: x #: ST: *Zip:
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E         Telephone #:       Fa         *Address (for payment of claims):       *         *City:       *         *Tax ID #:       Is thi         *License #:       *	*Are you a billing service? Yes No xonomy Code (if known): -mail: x #: ST: *Zip:
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession: Medical Dental Other         Specialty:       Ta         Contact Name:       *E         Telephone #:       Fa         *Address (for payment of claims):       *         *City:       *         *Tax ID #:       Is thi         *License #:       *	*Are you a billing service? Yes No xonomy Code (if known): -mail: x #: ST: *Zip: s your Fed. ID # or Soc. Security # roup NPI#
*Apex Client ID (all applicable):         *Doctor or Provider of Services Name:         *Company Name (to be used on claims):         Profession:       Medical         Dental       Other         Specialty:       Ta         Contact Name:       *E         Telephone #:       Fa         *Address (for payment of claims):       *         *City:       *         *Tax ID #:       Is thi         *License #:       **G	*Are you a billing service? Yes No xonomy Code (if known): -mail: x #: ST: *Zip: s your Fed. ID # or Soc. Security # roup NPI#

\*Indicates required information

\*\*If you do not use a group NPI, please leave blank

To register these providers, **please fax this form to Apex at (801) 642-0333** in addition to the completed Electronic Services Agreement form. Phone: 800-840-9152