



SomnoMed Billing Services Dental Practice Intake Form

Practice Demographics

Practice/Business Name:	
DDS/DMD Name (as registered):	
Street Address/City/Zip:	
Phone:	Fed Tax ID/SSN:
Fax:	NPI:
Email:	Taxonomy Code:
Office Contact for Billing Concerns:	PTAN:
Office Contact Email Address:	

I authorize SomnoMed Billing Services to bill the following for each of my patient cases submitted for Billing Services:

Global Fee: \$	Services Provided, Not Included In My Global Fee:					
<i>My Global Fee Includes:</i>	Service	Code	\$	Service	Code	\$
Service	Code					

Electronic Payer Identification List

Please list each insurance company you are a provider with; use another sheet for additional payers:

Name of Payer (Insurance Company)	Capario Payer ID	Provider ID	NPI w/this Payer	Professional Transactions	Do you accept Medicare/Medicaid as Primary Payer

Please be advised:

This document is considered current and active for the twelve month period beginning with the date of the most current business agreement.

Dentist/Physician Signature: _____	Date: _____
------------------------------------	-------------

Please return via email to BillingServices@SomnoMed.com or fax to 214-436-4198.