


 Minnesota Department of **Human Services**
*Minnesota Health Care Programs (MHCP)*

# Provider Setup Form

**For use by Billing Intermediaries and Clearinghouses only.**

Use this form to notify DHS whenever providers are **added or removed** from your list. Copy as needed.

SUBMITTER ID (UMPI)		SUBMITTER NAME	
NAME OF PERSON COMPLETING THIS FORM		ADDRESS	
PHONE (     )	CITY	STATE	ZIP CODE

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

## MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER (     )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: <input type="checkbox"/> Claim <input type="checkbox"/> ERA <input type="checkbox"/> Both

Fax this form to MHCP Provider Enrollment at (651) 431-7462 or mail to  
 DHS Provider Enrollment  
 PO Box 64987  
 St. Paul, MN 55164-0987