

**UMMG - IDX  
BAR  
Dictionary Maintenance Form**

**PROVIDER DICTIONARY #3**

**REFERRING PHYSICIAN DICTIONARY #123**

*Please complete the form, obtain TPR approval and fax to UMMG-IDX.*

Date : \_\_\_\_\_

**PART A** Check the appropriate box:

**New Add** (complete Part B)       **Deactivate**       **Update**

**Division:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_ **Degree:** \_\_\_\_\_

**State License No.:** \_\_\_\_\_

**UMMG Faculty**     **Non-UMMG Faculty**     **Other :** \_\_\_\_\_ (Please Specify)

**Provider UMMG No.** \_\_\_\_\_ **JMH No .** \_\_\_\_\_

**Provider Medicare Individual No.** \_\_\_\_\_ **Medicare No. Effective Date:** \_\_\_\_\_

**Provider Medicaid Individual No.** \_\_\_\_\_ **UPIN** \_\_\_\_\_

**CMS Contracted? (for Pediatrics use only)**  **Yes**     **No**      **Champus No.** \_\_\_\_\_

**Facilities/Hospitals :** \_\_\_\_\_

**Is this a scheduling Provider?**  **Yes**     **No** (Please complete the appropriate Scheduling Forms)

Billing Area (s)	Medicare Group #	Medicaid Group #	FRS Account No.
1.			
2.			
3.			
4.			
5.			

**PART B**

**REFERRING PHYSICIAN**

**Address:** \_\_\_\_\_

**City, State, Zip Code:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_

**UPIN #:** \_\_\_\_\_

**B/S Specialty Code:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_

**Internal UMMG Physician**

**DEPT**      **Effective Date:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Submitted by:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_

**TPR**      **Approved by:** \_\_\_\_\_

**Date :** \_\_\_\_\_

**UMMG-IDX**      **Processed by:** \_\_\_\_\_

**Provider Numeric Code:** \_\_\_\_\_

**Provider Mnemonic:** \_\_\_\_\_

**Specialty Code:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Fax the completed form to Attn: Dictionary Maintenance at 243-7355.*

***Please keep a copy for your departmental records.***