



Submit to your local  
Provider Relations  
representative

## National Provider Identifier (NPI) Submission Form (Type 2 – Organizational)

| Provider Information Type 2 - Organizational (Primary)  |   |   |                   |
|---|---|---|-------------------|
| 1. Provider's Full Name (Facility Name or Individual's Name – Last, First, MI)  |   | 1a. Check below if Name is Pay-to-Provider/Vendor<br><input type="checkbox"/> | 2. County         |
|   |   | 3. State  |                   |
| 4. Tax ID Number  | 5. WellCare Provider ID                               | 6. Ohio Medicaid ID   |                   |
| 7. NPI (10-digit number)  | 8. Practice Location (Street, City, State, Zip Code)  | 9. Specialty  | 10. Taxonomy Code |
| Contact Information   |   |   |                   |
| 11. Contact Person Name   |   | 12. Telephone Number  | 13. Fax Number    |
|   |   | ( ) - -   | ( ) - -           |
| National Provider ID Type 2- Organizational (Subparts) –<br><i>For organizations only, please disclose your subpart enumeration if applicable</i> |   |   |                   |
| 14. NPI (10-digit number)   | 15. Practice Location (Street, City, State, Zip Code) | 16. Specialty   | 17. Taxonomy Code |
|   |   |   |                   |
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**\*\* If you require more rows, please continue this section on another page. \*\***