CLIENT REGISTRATION FORM
HCU, Inc

Practice / Clinic		Payment / Correspondence (HCFA BOX 33 Info)
	Name	Same
	Address	Same
	City, St, Zip	Same
	County	Same
	Phone Number	Same
	Fax Number	Same
	Contact Name	Same

Specialty (Required)

3 Digit Specialty Code (Required)

Tax ID Number
Type EIN ☐ **SS** ☐
(Required)

Site #

Payer Name	Individual Provider #	Group Provider #
Blue Cross Blue Shield		
Medicare		
Medicaid		
Railroad Medicare		
Champus		
Other		

NOTES

License #
IND NPI#

GRP NPI#