



www.HealthXnet.com
Support: 505-346-0290
Toll Free: 866-676-0290
PO Box 92200
Albuquerque, NM 87199-2200

FACILITY ENROLLMENT FORM

FAX Completed & Signed form to (505) 346-0278 or email healthxnet@nmhsc.com

Or mail to: HealthXnet Support, PO Box 92200, Albuquerque, NM 87199-2200

ACCOUNT

Company information for your HealthXnet account.

Company Name:

Mailing Address:

City, State, Zip:

Main Phone:

AUTHORIZED REQUESTOR (ACCOUNT CONTACT)

This person is the group contact for your account set up. S/he is authorized to add/remove users on your account, receive reports.

Name:

Title:

Phone:

Email:

FACILITY INFORMATION

The facility to be set up in HealthXnet.

More than one facility location and/or NPI? You can send us the details below for each facility via email or in a report attached to this form.

Facility Name:

Phone:

Street Address:

City, State, Zip:

Fax:

Facility NPI:

Facility Tax ID:

PRACTITIONER INFORMATION

Individual(s) performing billable services at the above facility.

Need to add more providers? You can send us the details below for each provider via email or in a report attached to this form.

Rendering Provider Name:

Main Address:

Phone:

Main City, State, Zip:

Fax:

Servicing Address:

Servicing City, State, Zip:

Email:

Practitioner NPI:

Affiliated with Tax ID:

Completed
By (Print Name):

Signature: X

FACILITY #2 (if applicable)	<p style="color: blue; margin: 0;">The facility to be set up in HealthXnet.</p> <p style="font-size: small; margin: 0;"><i>More than one facility location and/or NPI? You can send us the details below for each facility via email or in a report attached to this form.</i></p>
Facility Name:	Phone:
Street Address:	
City, State, Zip:	Fax:
Facility NPI:	Facility Tax ID:

PRACTITIONER #2	<p style="color: blue; margin: 0;">Individual(s) performing billable services at the above facility.</p> <p style="font-size: small; margin: 0;"><i>Need to add more providers? You can send us the details below for each provider via email or in a report attached to this form.</i></p>
Rendering Provider Name:	
Main Address:	Phone:
Main City, State, Zip:	Fax:
Servicing Address:	
Servicing City, State, Zip:	Email:
Practitioner NPI:	Affiliated with Tax ID:

PRACTITIONER #3	<p style="color: blue; margin: 0;">Individual(s) performing billable services at the above facility.</p> <p style="font-size: small; margin: 0;"><i>Need to add more providers? You can send us the details below for each provider via email or in a report attached to this form.</i></p>
Rendering Provider Name:	
Main Address:	Phone:
Main City, State, Zip:	Fax:
Servicing Address:	
Servicing City, State, Zip:	Email:
Practitioner NPI:	Affiliated with Tax ID:

PRACTITIONER #4	<p style="color: blue; margin: 0;">Individual(s) performing billable services at the above facility.</p> <p style="font-size: small; margin: 0;"><i>Need to add more providers? You can send us the details below for each provider via email or in a report attached to this form.</i></p>
Rendering Provider Name:	
Main Address:	Phone:
Main City, State, Zip:	Fax:
Servicing Address:	
Servicing City, State, Zip:	Email:
Practitioner NPI:	Affiliated with Tax ID:

Completed By (Print Name):	Signature: X
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