OKLAHOMA HEALTH CARE AUTHORITY
APPENDIX A

Health-Care Providers for Whom Group Receives Payment

Group Name ____

Oklahoma Medicaid Group ID ___________________Group FEIN _______________________
(10 digit group ID) *(Federal Employer Identification Number)*

NPI ______________________________

By signing this document, each PROVIDER appoints the above-named GROUP as his or her agent for receipt of payment for Medicaid-compensable health-care services and directs the Oklahoma Health Care Authority (OHCA) to make all such payments to GROUP in keeping with the Agreement attached hereto, regardless of any other Agreement PROVIDER has with OHCA. No payments will be made directly to the rendering provider. Each PROVIDER accepts all terms and conditions in the attached Agreement.

Effective Date ______________________________ NPI ____________________________
(Date provider appoints the above group to receive payments)
Provider Name ____
(Last) *(First)* *(Middle)* *(Title)*
Oklahoma Medicaid Provider ID _____________________ SSN __ __ __ - __ __ - __ __ __ __
(10 digit provider ID) *(Social Security Number)*
Provider Signature ____________________________ Date _________________

Effective Date ______________________________ NPI ____________________________
(Date provider appoints the above group to receive payments)
Provider Name ____
(Last) *(First)* *(Middle)* *(Title)*
Oklahoma Medicaid Provider ID _____________________ SSN __ __ __ - __ __ - __ __ __ __
(10 digit provider ID) *(Social Security Number)*
Provider Signature ____________________________ Date _________________

Effective Date ______________________________ NPI ____________________________
(Date provider appoints the above group to receive payments)
Provider Name ____
(Last) *(First)* *(Middle)* *(Title)*
Oklahoma Medicaid Provider ID _____________________ SSN __ __ __ - __ __ - __ __ __ __
(10 digit provider ID) *(Social Security Number)*
Provider Signature ____________________________ Date _________________

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