JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
PROVIDER DATA EXCHANGE FORM

Instructions: This form must be completed in order to ensure the accuracy of our provider data files as well as the proper processing of provider claims submitted to Jai Medical Systems Managed Care Organization, Inc. (JMSMCO). Please type or print legibly and submit form to JMSMCO prior to sending claims. Please be sure to submit a completed JMSMCO Provider Data Exchange form with a completed W-9 form for tax reporting purposes. If you are a group provider, this form should be completed for every participating provider within your group. In addition, please complete this form for each and every service location. This form is available online at www.jaimedicalsystems.com. Completed forms should be submitted to providerrelations@jaimedical.com.

SECTION I – TRANSACTION TYPE & EFFECTIVE DATE (*Internal Use Only*)	
1. Please check one. ☐ Add Provider ☐ Change Provider ☐ Terminate Provider	2. Effective Date

SECTION II – PROVIDER INFORMATION *(To be completed by provider)*		
3. Organization Name (if applicable)		4. Provider Gender ☐ Male ☐ Female ☐ N/A
5. Provider Last Name	6. Provider First Name	
7. Address 1 (Street)		
8. Address 2 (Apt/Suite)	9. Office Phone Number	10. Office Fax Number
11. City	12. State	13. Zip Code
14. Provider E-mail Address		
15. Provider Type ☐ Primary Care Provider (PCP) ☐ Specialty Care ☐ Hospital Facility ☐ Ancillary Care ☐ Other _____		
16. If PCP, are you currently accepting new patients? ☐ Yes ☐ No	17. If you answered question 16 with yes, what is your patient age range?	
18. Specialty – Please list all.		
19. Board Certified? ☐ Yes ☐ No	20. EPSDT Certified? ☐ Yes ☐ No	21. EPSDT Certification –Effective Date
22. Hospital Privileges? ☐ Yes ☐ No (If yes, please list below. *Individual providers only*.) a) _____ b) _____ c)_____		

SECTION III – PROVIDER CONTACT INFORMATION *(To be completed by provider)*	
23. Name – Contact Person	24. Title – Contact Person
25. Telephone – Contact Person	26. E-mail Address – Contact Person

SECTION IV – PROVIDER TAX REPORTING INFORMATION *(To be completed by provider)*		
Taxpayer Information		
27. Taxpayer Name – as shown on your income tax return.	28. Business Name (if applicable)	
Pay-to Address		
29. Pay-to Name		
30. Address 1		31. Address 2 (Apt/Suite)
32. City	33. State	34. Zip Code

SECTION V - PROVIDER IDENTIFICATION NUMBERS *(To be completed by provider)*	
35. Tax ID #	36. SSN #
37. Group NPI # (if applicable)	38. Individual/Rendering NPI #
39. Medicaid #	40. Maryland License #
41. CDS # (if applicable)	42. DEA# (if applicable)

I hereby attest that the Provider Data Exchange form and W-9 form have been completed and verified as accurate. *(To be completed by the provider who completed this form or the person who completed this form on behalf of the provider.)*

Print Name: _____

Signature: _____ Date: _____

JMSMCO INTERNAL USE ONLY	
Provider Status – □ Participating Provider - Contract Effective Date _____ □ Non Participating Provider □ Self Referral Provider □ Emergent/Urgent Care Provider	**Notes:**
Completed by: _____ Completion Date: _____ Amisys Affiliation #: _____	**Provider Configuration Notes – Please indicate applicable fee schedule.**