

**Storm Medical Billing - Client Intake Form:
Health Care Provider Practice Information**

**Your secure toll free fax number is (888)508-2108
Please fax all documents. Do not mail.**

Practice Name: _____

Street Address: _____

City: _____

State: _____ **Zip:** _____

Phone Number : _____

Fax Number : _____

E-mail: _____

Medical Office Type: _____

Federal Tax ID: _____ **EIN** _____ **SS** _____

Provider NPI _____

Group NPI _____

Claims are submitted _____ **daily** _____ **wk** _____ **semi mo** _____ **mo** _____

Names of Insurance Companies you have Credentials with:

