Instructions for Request for Assignment of Fees

This form **MAY be used to add a fee assignment to an existing individual provider service location only.**

Enter the name of the physician who will be assigning his/her fees. Provide the individual physician’s nine–digit Promise ID number.

Lines 1 – 5:
List the individual physician’s four–digit service location designation (one per line). Provide the group name and 13–digit Promise ID where the fees will be assigned. Fill in the date the fee assignment is to be effective (no more than 12 months prior to receipt of document).

Please date and print the provider’s name. An *Original* signature from the provider is required.

Please provide a contact name and phone number and/or email address in case there are questions about this document.

**Please return to:**
Bureau of Fee-for-Service Programs
Division of Operations – Provider Enrollment
Section P.O. Box 8045
Harrisburg, PA 17105-8045

OR

**Email:** RA-ProvApp@pa.gov
Request for Assignment of Fees

Individual Practitioner Name: ____________________________________________________

Individual Provider Number (9-Digit): __ __ __ __ __ __ __ __ __

Please assign my fees from the following service location(s) to the listed group(s):

<table>
<thead>
<tr>
<th>Service Location</th>
<th>Assign fees to</th>
<th>PROMISE 13-Digit</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group Name</td>
<td>Provider Group Number</td>
<td></td>
</tr>
<tr>
<td>1. ___ ___ ___</td>
<td>__________________________</td>
<td>____________________________________</td>
<td>______________</td>
</tr>
<tr>
<td>2. ___ ___ ___</td>
<td>__________________________</td>
<td>_______________________ _____________</td>
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<tr>
<td>3. ___ ___ ___</td>
<td>__________________________</td>
<td>_______________________ _____________</td>
<td>______________</td>
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<tr>
<td>4. ___ ___ ___</td>
<td>__________________________</td>
<td>_______________________ _____________</td>
<td>______________</td>
</tr>
<tr>
<td>5. ___ ___ ___</td>
<td>__________________________</td>
<td>_______________________ _____________</td>
<td>______________</td>
</tr>
</tbody>
</table>

By Signing, I am agreeing to assign my fees to the group(s) named, and service location number listed above.

________________________        __________________________
Date                              Print or Type Provider Name

_________________________________________________________
Original Provider Signature (Signature Stamps Not Accepted)

**This is the contact name and phone number we will use if we have any questions about this document.

Contact Name: ____________________________________________________

Phone: ____________________________ E-Mail Address: ____________________________

05/13/13