Clear Form Data
FILLABLE FORM

DHS-4087-ENG 9-08

Minnesota Department of Human Services

Minnesota Health Care Programs (MHCP)

Provider Setup Form

For use by Billing Intermediaries and Clearinghouses only.

Use this form to notify DHS whenever providers are **added or removed** from your list. Copy as needed.

SUBMITTER ID (UMPI)	SUBMITTER NAME		
A603517500	Lindsay Technical Consultants, Inc.		
NAME OF PERSON COMPLETING THIS FORM: Gary Lindsay	ADDRESS: 42496 Lindsay Drive		
PHONE: (507) 947-3070	CITY: North Mankato	STATE: MN	ZIP CODE: 56003

MHCP Pay-To Provider

PAY-TO PROVIDER NAME	NPI/UMPI	LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER CONTACT NAME	PHONE NUMBER ( )	REMOVE LINK TO OUR SUBMITTER ID – EFFECTIVE DATE (MM/DD/YYYY)
PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: ☐ Claim ☐ ERA ☐ Both

MHCP Pay-To Provider

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PAY-TO PROVIDER SIGNATURE	DATE (MM/DD/YYYY)	CHOOSE ONE: ☐ Claim ☐ ERA ☐ Both

Fax this form to MHCP Provider Enrollment at (651) 431-7462 or mail to
DHS Provider Enrollment
PO Box 64987
St. Paul, MN 55164-0987