



Submit to your local  
 Provider Relations  
 representative

## National Provider Identifier (NPI) Submission Form (Type 1 – Individual)

Provider Information Type 1 - Individual		
1. Provider's Full Name (Last, First, Middle Initial)		2. County
		3. State
4. Social Security Number - -	5. WellCare Provider ID	6. Medicaid ID
7. Practice Location (Street, City, State, ZIP Code)	8. Provider Date of Birth	9. Medical License Number
10. NPI (10-digit number)	11. Specialty	12. Taxonomy Code
Contact Information		
13. Contact Name	14. Telephone Number	15. Fax Number
	( ) - -	( ) - -

**\*Please provide as much information as possible.**