Provider Registration Form

Facility ◯ Professional ◯

Provider Name:_____

Address:_____

TIN:_____ NPI#:_____

Contact Person Name: _____ _____

First Name Last Name

Submit competed form to : customerservice@significabenefits.com or fax to: 717-581-8379

Please attach the following:

- W-9, to confirm correct 1099 TIN information on file

Allow 2 business days for processing before registering.

Visit: www.significabenefits.com to:

- Check eligibility such as effective date, termination dates and dependent coverage
- Check deductible, accumulators and copays
- Check status of claim
- Balances for FSA or HRA
- View/print EOB
- View/print ID card and more