GOVERNMENT OF PUERTO RICO

Department of Health
Medicaid Program

Provider Enrollment Consent Form

Instructions: To be completed by providers with enrollment type of Individual, Individual within Group, and Ordering/Prescribing/Referring (OPR). The Form must be completed in all its parts, dated, and duly signed by the enrolling provider. Signed by hand or validated electronic signature are required; typed-in signatures are not allowed. Complete and submit one form for each Provider Enrollment Application and/or Provider Revalidation. Select only **ONE** of the attestations below.

Individuals, Individuals within Groups, and OPR providers must include this form with their enrollment application/revalidation in Provider Enrollment Portal (PEP). Applications with enrollment type of Group, Facility and Clinic are not required to complete this form; in its place, a statement can be attached to the PEP application indicating that the form does not apply for the enrolment type.

Provider Name		**Provider NPI #**
Address Line 1 *(Number and Street Name, or PO Box)*		**Address Line 2** *(Suite, Office #, Building Name, etc.)*
City	**State**	**Zip Code +4**
Telephone Number	**Email Address**	
( ) - Ext.		

Check ONE of the following attestations:

☐ By my signature below, I attest that _____ is authorized to
(Enter the name of authorized person/entity)
submit my provider enrollment application/revalidation which includes Personally Identifiable Information (PII) on my behalf. I understand that I am still responsible for any actions performed under this delegation.

☐ By my signature below, I attest that no one else is authorized to submit my provider enrollment application/revalidation on my behalf.

Provider Signature: _____ Date: _____

Printed Provider Name: _____