

# Private Fee-for-Service (PFFS) Website Registration Form

Please return the complete signed and dated form with a copy of your W-9. A representative from Bravo Health's PFFS Provider Relations Department will contact you within 24 hours to confirm your account information.



<b>Date:</b>
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Provider Information		
<b>Provider First Name:</b>	<b>Provider Last Name:</b>	
<b>Provider Phone:</b>	<b>Provider Fax:</b>	
<b>Provider Practice Name:</b>		
<b>Provider Street Address:</b>		
<b>Provider City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Provider Email Address:</b>		

Provider Contact Person (e.g., office manager)	
<b>Name:</b>	<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>
<b>Address (if different from above):</b>	

Provider Practice Information	
<b>Provider Specialty:</b>	
<b>Facility Name (if applicable):</b>	
<b>Practice Group Name (if applicable as shown on W-9):</b>	
<b>Tax ID#:</b>	<b>NPI#:</b>
<b>Are you a solo provider?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>How many providers are in the practice?</b>
<b>How many locations are affiliated with the practice?</b> _____ (Please list below)	
<b>Are you affiliated to IPA or PHO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    (Please list affiliations below)	

**Provider Claim Payment Information**

Please provide us with information for claims payment. The information listed in this section should match that listed on the claims you submit to us for payment.

<b>Payee Name:</b>		
<b>Payment Address:</b>		
<b>Payment City:</b>	<b>State:</b>	<b>Zip:</b>

**Provider Acceptance of Bravo Health PFFS Members**

<b>Will you accept Bravo Health PFFS members?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Will you accept Bravo Health PFFS members on a patient-by-patient basis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Provider Signature:</b>	<b>Date:</b>

If you have questions about Bravo Health's Terms and Conditions of Payment, or to return the completed web registration form, contact Bravo Health's PFFS Provider Relations Department in your area:

**Bravo Health Provider Relations Department (PFFS)**E-mail: [pffsinq@bravohealth.com](mailto:pffsinq@bravohealth.com)

Hours: Monday through Friday, 8:00 am to 5:00 pm, EST

**Mid-Atlantic Contact:**


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Donna Cox                      Phone: 1-443-573-1632  
 Bravo Health, Inc.        Fax:    1-800-447-0465  
 3601 O'Donnell Street  
 Baltimore, MD 21224

**El Paso (TX) Contact:**


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Karla Rincones              Phone: 1-915-577-4149  
 Bravo Health, Inc.        Fax:    1-915-577-4196  
 4141 Pinnacle Street  
 Suite 109  
 El Paso, TX 79902

**San Antonio (TX) Contact:**


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Tristan Jackson            Phone: 1-210-321-7763  
 Bravo Health, Inc.        Fax:    1-210-340-9074  
 7551 Callaghan  
 Suite 310  
 San Antonio, TX 78229

**Dallas/Ft. Worth (TX) Contact:**


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Jacqueline Ban              Phone: 1-214-436-4234  
 Bravo Health, Inc.        Fax:    1-469-362-6628  
 6801 Gaylord Parkway  
 Suite 401  
 Frisco, TX 75034

**Houston (TX) Contact:**


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Esmeralda Malone        Phone: 1-713-454-8468  
 Bravo Health, Inc.        Fax:    1-713-643-5981  
 1225 North Loop West  
 Suite 127  
 Houston, TX 77008