The Exclusive Provider Health
Plan of the County of Riverside

PAYMENT REMITTANCE INFORMATION

Exclusive Care Health Plan EPO
and
Health Care Provider

IDENTIFYING INFORMATION OF THE PROVIDER:

Legal Name of the company as it appears on the W-9 tax form: __________

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Tax I.D. Number: ______________________________________

NPI: ____

Billing Phone#: _______________________________________

Billing Fax#: ____

Email: ____

PLEASE SEND MY CHECKS TO THE FOLLOWING ADDRESS:
(do not reference any other section of the application, this area must be completed and signed by the provider and must match the W-9 form)

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____

Attach your w-9 tax information form to this addendum

______________________________ ______________________

Provider Signature **Date**

SUBMIT CLAIMS TO:

Exclusive Care Health Plan
Po Box: 1508
Riverside, Ca 92502-1508
EDI: Office Ally
Payer ID EC999