MEDICAID PROVIDER ENROLLMENT APPLICATION

RETURN THIS FORM TO:

Provider Enrollment
National Heritage Insurance Co.
7800 Shoal Creek Blvd.
Austin, Texas 78757

FOR NHIC USE ONLY

CLERK	DATE	CONTROL NUMBER

NOTICE: PLEASE NOTIFY THIS DEPARTMENT OF ANY CHANGES TO THE ABOVE INFORMATION INCLUDING ADDRESS TO PREVENT CLAIM REJECTS OR WRONG PAYMENTS.

ALL INFORMATION MUST BE COMPLETED OR MARKED N/A, AND CONTAIN A VALID SIGNATURE TO BE PROCESSED.

A. PROVIDER OF SERVICE INFORMATION

APPLICANT NAME (INDIV, GROUP, INC. DBA — SHOW AS LICENSED)
JOHN M. MACKENZIE M.D.
LAST/OR GROUP/OR COMPANY — FIRST — MIDDLE INITIAL

TITLE/DEGREE: M.D.

TELEPHONE NUMBER (AREA CODE): (817) 335-2329

TYPE OF PROVIDER (PRIMARY SPECIALTY): OB-GYN

ADDRESS NO. 1 PHYSICAL ADDRESS (PRACTICE LOCATION)
1080 W. DASHWOOD
NUMBER — STREET — ROOM/SUITE
FT. WORTH, TEXAS TARRANT 76104
CITY — STATE — COUNTY — ZIP

ADDRESS NO. 2 ACCOUNTING ADDRESS/MAIL CHECK TO: (IF SAME AS ADDRESS NO. 1, WRITE SAME)
SAME
NUMBER — STREET
CITY — STATE — ZIP

B. BILLING INFORMATION

NAME AND SIGNATURE OF PERSON AUTHORIZED TO SIGN FOR PROVIDER
JOHN M. MACKENZIE MD [signature]
NAME — TITLE — SIGNATURE

FISCAL YR. END: SEPT (MONTH)

License # E0346
(Attach COPY if Temporary)
Effective Date: 6-73

IRS TAX # 75-1730815 TYPE (CHECK ONE) ☒ E = EMPLOYER I.D. # ☐ S = SOCIAL SECURITY #

IF EYEGLASS PROGRAM PARTICIPANT, PLEASE SPECIFY OPTION. A B

WHAT IS YOUR MEDICARE PROVIDER NUMBER? 1000 N-8183

IF YOU WILL NEVER BILL THE MEDICARE PROGRAM DUE TO YOUR SPECIALTY OR PRACTICE, CHECK HERE ☐.

C. GROUP PRACTICE APPLICATION

LIST ALL INDIVIDUALS PROVIDING SERVICES BELOW OR ON ATTACHMENT.

STATE LICENSE NO.	NAME/LOCATION IF DIFFERENT FROM A.	TITLE/SPECIALTY	SOCIAL SECURITY #	MEDICARE # WITHIN GROUP
	Removed Code 38 on 8/10/92 DC			

D. OTHER INFORMATION

Is this location:

A. Full Time ✓
Part Time ____

B. Located within a hospital? Yes ____ No ____

C. In addition to other Practice locations? Yes ____ No ____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SUPPLIED ON THIS DOCUMENT IS ACCURATE AND COMPLETE AND IS HEREBY RELEASED TO NATIONAL HERITAGE INSURANCE COMPANY FOR THE PURPOSE OF ISSUING A MEDICAID PROVIDER NUMBER.

SIGNATURE OF APPLICANT
X [signature] MD
SIGNATURE

President — 8-2-82
TITLE — DATE

DO NOT WRITE IN THIS AREA

CO	SPEC	TYPE	LOCALITY	EFFECTIVE DATE

____ Signed DHR Contract
____ Approved UR Plan
____ Added and/or Enrolled ____ Send Provider Manual

Clerk ________ Date ________

TXIX 240

E. D. S. FEDERAL CORPORATION

2023305769030

PROVIDER INFORMATION DATA FORM

NAME DATA:

If Individual
LAST NAME: Mackenzie
FIRST NAME: John
INITIAL: M
TITLE: MD

If Group or Company
NAME: John M. Mackenzie M.D.

ADDRESS:

Physical Address
STREET: 1080 W. Dashwood
CITY: Ft. Worth
STATE: Texas
ZIP CODE: 76104
PHONE: (817) 335-2329

Accounting Address

0

Blue Cross/Shield Provider Number N 818
IRS Tax # 138-32-6480 Type S
E = Employer Identification Number
S = Social Security Number

State License # E 0346
Narcotic License # AM 5429065

PHYSICIANS:

Field of Specialty: OB-GYN

EYEGLASS SUPPLIERS:

Eyeglass Option ______ (A or B)

LABS:

Lab Certification # ______

NATIONAL HERITAGE INSURANCE COMPANY

Austin, Texas 78757

Exchange Park
7800 Shoal Creek Blvd.
(512) 458-5111

O3OOO6JWOWWW NOOW

7-27-82

John M. MacKenzie MD
1080 W. Dashwood
Fort Worth, Tx 76104

Dear Sir:

The National Heritage Insurance Company (NHIC) has cancelled your Medicaid Provider number P000N8183. This action was taken because We show that there had been no claims filed on this number over a period of one year. However if you wish to have your number reinstated please complete the attached Medicaid Provider Enrollment Application and return it to us with any claims you have pending.

If you have any questions please call.

Sincerely

Deborah Roberts

Deborah Roberts
Unit Analyst
Provider Enrollment

DR:dr

NATIONAL HERITAGE INSURANCE COMPANY

Austin, Texas 78757
Exchange Park
7800 Shoal Creek Blvd.
(512) 458-5111

0W0007J30153HN002

8/10/82

John MacKenzie MD
1080 W Dashwood
Ft Worth, TX 76104

Dear Sir:

Thank you for your request to be reinstated into the Medicaid (Title XIX) Program. Your Medicaid Provider number P000N8193 has been reactivated. Any claims with dates of service 90 days prior to the date on this letter can be processed.

A supply of labels and forms has been ordered for your Medicaid claims filing. If we can be of further service to you please let us know.

Sincerely,

Debbie Cain

Debbie Cain
Enrollment Analyst
Provider Enrollment

DC:dr

E. D. S. FEDERAL CORPORATION

2002135037000030

PROVIDER INFORMATION DATA FORM

NAME DATA:

If Individual
LAST NAME: MACKENZIE
FIRST NAME: JOHN
INITIAL: M
TITLE: MD

If Group or Company
NAME: ______

ADDRESS:

Physical Address
STREET: 1080 W. DASHWOOD
CITY: FORT WORTH
STATE: TEXAS
ZIP CODE: 76104
PHONE: (817) 335-2329

Accounting Address
______

Blue Cross/Shield Provider Number P000N 8183
IRS Tax # 138-32-6490 Type S
E = Employer Identification Number
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State License # E 0346
Narcotic License # AM 5429065

PHYSICIANS:

Field of Specialty: ______

EYEGLASS SUPPLIERS:

Eyeglass Option ______ (A or B)

LABS:

Lab Certification # ______