

**Sentara Health Plans  
Billing Company/Consultant Registration/  
Notification Form**

**Provider/Facility**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Contracted Billing**

**Company/Consultant:** \_\_\_\_\_

Contract Effective date: \_\_\_\_\_ End date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Tax ID# \_\_\_\_\_

Contact Person: \_\_\_\_\_

Date Business Associate Agreement Signed: \_\_\_\_\_

**Copy of Business Associate Agreement or signed attestation must be submitted with this form.**

By submitting this request form, I hereby agree to notify Sentara Health Plans immediately upon the termination of the Agreement with the above named billing company/consultant.

Date: \_\_\_\_\_

By: \_\_\_\_\_

**Fax form to:**

**or**

**Mail form to :**

**SHP Provider Relations  
757-552-7316**

**SHP Provider Relations  
4417 Corporation Lane  
Virginia Beach, VA 23462**