Provider Network Participation Request Form

The information contained here is privileged and confidential.

This document must be completed in all its parts, in the boxes that do not apply please write N/A.

Provider Name		**Billing Name**	
Rendering NPI		**Billing NPI**	
Specialty		**Tax Id**	
Email:			

Medicare Advantage				**Plan de Salud del Gobierno**	
MMM	*PMC*	*First+Plus*		*MMM Multi Health Northeast Region*	*MMM Multi Health Southeast Region*

For Primary Care Physicians (PCP) contract, please include the IPA or/and PMG Name and any Intetion Letter, if apply.

IPA Name		**PMG Name**	
IPA Administrator Signature		**PMG Administrator Signature**	

Contract Request Type

☐ Corporate Contract	☐ Individual Contract	☐ Group Contract	☐ Contract Termination	☐ Add to Group	☐ Add Specialty	☐ Add Service	☐ Demographic Change
☐ Rate Change	☐ Service Change	☐ Specialty Change	☐ Vendor Change	*Explain:*		☐ Other	

Primary Location address	Address :		**Billing address**	Address :	
	Phone:			Phone:	
	Fax:			Fax:	

Hospital Privileges	**Hospital Name**						
Bussines Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Additional Comments:

Applicant Signature

Date

Please remit filled form to email at ***providerrequest@mso-pr.com***

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