MASS ADVANTAGE

Mass Advantage requires the information below to fully evaluate your request to become a participating provider.

Please submit completed form to Mass Advantage Provider Relations via email at provider.relations@massadvantage.com.

Date:

Facility/Organization Specialty (please check all that apply)		
☐ Acute Rehabilitation Facility	☐ Home Infusion	☐ Urgent Care
☐ Ambulatory Surgical Center	☐ Hospital	☐ Physical Therapy
☐ Ambulance	☐ Laboratory/Genetics	☐ Other (please specify):
☐ Dialysis	☐ Skilled Nursing Facility	
☐ DME	☐ Sleep Laboratory	
☐ Home Health/Hospice	☐ Radiology/Diagnostic Imaging Facility: ☐ CT ☐ MRI ☐ PET ☐ Ultrasound	

Facility/Organization Information			
Physical Location (Address where services are rendered, if applicable): (If you have additional physical locations, please attach a separate list including address, phone number, contact name, TIN, and NPI for each location.)			
Tax ID:			
NPI:			
Facility Name:			
Facility Address:			
Phone Number:		**Fax Number:**	
Email Address:			
Website Address:			

Primary contact name, telephone number, and email address

Please include list of provider names and their NPIs on the following page if applicable.

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Provider Full Name	NPI:									