MASS ADVANTAGE

Mass Advantage requires the below information to fully evaluate your request to join our network.

Please submit completed form to Mass Advantage Provider Relations via email at Provider.Relations@massadvantage.com. If you have any questions on completing the form, please reach out to Provider Relations at the above noted email address.

**Date:**

| **Name and Clinical Degree (i.e., MD, DO, NP, DMD, etc.)** | |
|---|---|
| | |
| **Legal Entity Name if different from above (i.e., group name)** | |
| | |
| **Name and title of individual authorized to execute the contract (if different from above)** | |
| | |
| **Board Specialty** | |
| | **If primary care, will you hold a panel?** Yes ☐ No ☐ |
| **Description of services to be provided:** | |
| | |

| **Practice Demographics (address, phone number, and website, if applicable)** | | | |
|---|---|---|---|
| | | | |
| **Primary contact name, telephone number, and email address (if different than above)** | | | |
| | | | |
| **Tax ID:** | | **NPI:** | |

| **Hospital affiliation(s) and/or collaborating physician/admitting arrangements:** |
|---|
| |