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 to write n/a.

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

Medicare Advantage	**Plan Vital (Gobierno de Puerto Rico)**
☐ MMM ☐ MMM Platino	☐ MMM Multi Health LLC

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

IPA Name (for Medicare Advantage)		**PMG Name (for Plan Vital)**	
IPA Administrator Signature		**PMG Administrator Signature**	

CONTRACT REQUEST TYPE

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

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

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

Additional Comments:

Applicant Signature	Date

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