



Vermont Medicaid Department of Human Services Group Affiliation Request Form

Please fax completed form to 802 878-3440 Attn: Provider Enrollment

ADD PROVIDER

Provider Number: _____ **Provider Name:** _____

Add to Group Number: _____ **as of** _____ (date provider is to be added)

Physical Service Address of physician being added to group

(cannot be a P.O box addresses)

(If there are additional Service Locations for the Group, please include additional pages.)

Phone Number: _____ **Fax Number:** _____

Handicap Accessible: Yes _____ No _____

Patient Age Range:

All _____ Newborn _____ Ages (from) _____ (to) _____

Accepting New Patients: Yes _____ No _____

Authorized Signature: _____ **Title:** _____ **Contact Number:** _____

REMOVE PROVIDER

Provider Number: _____ **Provider Name:** _____

Remove from Group Number: _____ **as of** _____ (date provider is to be removed)

Physical Service Address of physician removed from group

(cannot be a P.O box addresses)

(If there are additional Service Locations for the Group, please include additional pages.)

Phone Number: _____ **Fax Number:** _____

Handicap Accessible: Yes _____ No _____

Patient Age Range:

All _____ Newborn _____ Ages (from) _____ (to) _____

Accepting New Patients: Yes _____ No _____

Provider Signature or Signature of Authorized Party: _____ **Date Signed:** _____

Title of Authorized party: _____ **Contact Number:** _____