



Vermont Medicaid

Department of Human Services

Group Affiliation Request Form

Fax Form to 802-878-3440 Attn: Provider Enrollment

Individual Name _____

Individual Provider Number _____

Group Name _____

Add or Remove From Group Number (s) _____

Add or Remove From Group Numbers(s) _____

Service Location Address _____

Service Location Address _____

(cannot be a PO Box) _____

(cannot be a PO Box) _____

Phone Number _____

Phone Number _____

Fax Number _____

Fax Number _____

Handicap Accessible: Y__N__ Language _____

Handicap Accessible: Y__N__ Language _____

Patient Age Limits: All__Newborn__Age Range __to__

Patient Age Limits: All__Newborn__Age Range __to__

Accepting New Patients: Y__N__

Accepting New Patients: Y__N__

(Please use extra page(s) for more locations)

New Group Member(s)

Provider Name (Please Print)	VT Medicaid Number	EFF. DATE W/GROUP	NPI Number	Taxonomy	Requested by (Please Print)

Signature of Requestor _____ Date _____ Phone Number _____