List of MassHealth Provider Identification Numbers

Provider Name:_____

MassHealth Provider Identification Number	Please indicate what type of MassHealth provider this is:

Date:_____

Signature:_____

Printed Name of Person Signing:_____

TO BE COMPLETED BY ASAP ONLY

ASAP NAME: _____

ADDRESS: _____

CONTACT NAME: _____

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

MASSHEALTH PROVIDER ID: _____