Provider Participation Form

(Please complete one form for each provider at your facility)

Provider Name _____ Credentials _____ Specialty _____

Practice / Facility Name _____

Address _____ City _____ Zip Code _____

Phone _____ Fax _____ Email _____

Contact to *schedule* MSP Appointments: _____

Office Manager / MSP Contact: _____

Please list language(s) of fluency: _____

Do you have other office locations? ☐ Yes ☐ No ***(Please complete the back of this form)***

Address _____ City _____ Zip Code _____

Phone _____ Fax _____ Contact: _____

Please let us know if the services listed below are provided by your practice:

Service	Yes	No	Service	Yes	No
EKG	☐	☐	Do you provide services to children younger than age 6?	☐	☐
Laboratory Services	☐	☐			
Sample Medications	☐	☐	Do you provide services to children with special health care needs?	☐	☐
X-Ray	☐	☐			

I am willing to provide _____ (How Many?) appointments per month for Medical Services Project referrals and agree to accept the following program-determined fee(s) as payment-in-full for services received during the office visit.

☐ $5.00 – Primary Care visits ☐ $10.00 – Specialty Care visits

☐ Instead of designating a certain number of appointments per month, I prefer to see children on an as-needed basis only (MSP staff should contact my office staff for authorization).

My participation is non-binding and can be cancelled at any time by notifying the Medical Services Project staff in writing, via mail, fax, or email.

Provider Signature _____ Date _____

Provider Name ______________________ Credentials __________ Specialty ______________

Practice / Facility Name ____

Address ______________________________ City ______________ Zip Code __________

Phone ________________ Fax ________________ Email ____________________

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Contact to *schedule* MSP Appointments: _________________________________

Office Manager / MSP Contact: ____

Please list language(s) of fluency: _____________________________________