

Physician Group Enrollment Form

NEW GROUPS

**To submit an application and group roster online, visit
www.massmed.org/groupenrollment.**

Or, fax this form and your group roster to (781) 893-2105 or mail materials to Membership Services, MMS, 860 Winter Street, Waltham, MA 02451-1411.



☐ **YES!** I am interested in the Group Enrollment Membership Discount. I am enclosing necessary details about my group's individual members. Please contact me about coordinating group enrollment.

Group ID (will be entered by the MMS): _____

Group Name: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Key Physician Contact: _____

Key Physician's Phone: _____ E-mail: _____

Group Administrator Name/Title: _____

Administrator's E-mail: _____

Group Medical Director's Name: _____

Total Physicians in Group: _____ Total Physicians for Group Enrollment: _____

☐ Please add AMA billing to my group enrollment.

Letterhead/List Attached ☐ YES ☐ NO

☐ Please contact me because I have questions concerning group enrollment.

Authorized individual (please print): _____

Title (please print): _____

Signature: _____ Date: _____

Questions? Contact the Member Information Center at groups@massmed.org or (800) 322-2303, ext. 7311.



**MASSACHUSETTS
MEDICAL SOCIETY**

Every physician matters, each patient counts.

860 WINTER STREET, WALTHAM, MA 02451-1411

TOLL-FREE (800) 322-2303, EXT. 7311 FAX (781) 893-2105 WWW.MASSMED.ORG