MHS Full Panel Add Request

All fields must be complete for processing. Please print legibly.

Date of Request ______________________________

Contact Name ______________________________

Contact Telephone ______________________________

Contact Fax ______________________________

Member Information

Member ID Number ______________________________

Member Name ______________________________

Social Security Number ______________________________

Member Address ______________________________

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Member (or parent/guardian) Signature Date

Provider Information

As a primary medical provider, I agree to add the listed member to my full panel.

Physician Name ______________________________

Physician Provider ID Number ______________________________

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Physician Signature Date

Fax completed form to MHS Member Services: (866) 912-1629

MAXIMUS Use Only:
Date Received ______________
Date Approved ______________
Date Denied ______________
Return Code/Reason ______________

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