AFFILIATE PROVIDER INFORMATION FORM

Provider First Name: _____

Provider Last Name: _____

Email Address*:_____

Main Phone Number: _____

Mailing Address: _____

Street Address: _____

I am working in Private Practice: ☐ I am working for an Organization: ☐

If yes to organization, which organization: _____

Insurances Accepted:

Which EBT treatment(s) do you provide?:

Training Details (Please provide information on when and how you were trained in each EBT listed above):

*Email address where you can be reached regardless of current employment.

Please email completed form to cttcreferral@umassmed.edu