Municipal Medicaid Program
Random Moment Time Study (RMTS)
District Contact Information

The purpose of this form is to identify the individual designated by a Municipal Medicaid Provider to provide information necessary for the administration of the quarterly RMTS on the behalf of the district. Please print legibly.

Provider Information

MassHealth Provider #:

MassHealth Provider Name:

NPI Number:

Contact Name:

Title:

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Address

Tel. #:

Fax #:

E-Mail:

Contact Information for Designated Provider of RMTS Information

Contact Name:

Start Date:

Title:

Address:

Tel. #:

Fax #: 508-856-7643

E-Mail

_____

Authorized District Signature
(*Required if designated contact not a district employee*)

_____

Date

Please submit completed form to:

University of Massachusetts Medical School
Municipal Medicaid Program
Fax: (508) 856-7643
Email: SchoolBasedClaiming@umassmed.edu