



Dear Physician:

Please sign the enclosed Participating Provider Agreement to join MetroWest Healthcare Alliance, Inc.

Please send agreements, along with a check in the amount of **\$1,000.00** made payable to:

**MetroWest Healthcare Alliance, Inc.**

Please return all information to:

Provider Enrollment  
MetroWest Healthcare Alliance  
67 Union Street, Suite 113  
Natick, MA 01760