



HCAS Provider Enrollment Form

Important: Please go to CAQH to submit additional practice information necessary to comply with state & federal provider directory requirements.

| | | | |
|-------------|---------------------|------------------|--|
| Date | Completed By | Telephone | Email Of Person Completing Form |
|-------------|---------------------|------------------|--|

Section 1: Provider Information

| | | | | | | |
|---|----------------|---|--|-------------------------------|---|---|
| | | | | | | M <input type="checkbox"/> F <input type="checkbox"/> Non-Binary <input type="checkbox"/> |
| Provider First Name | Middle Initial | Provider Last Name | Degree/Title | Social Security Number | Date of Birth | Gender |
| Provider Email Address: | | | | Languages spoken by provider: | | |
| Specialty: | | Board Certified? Yes <input type="checkbox"/> No <input type="checkbox"/> | If you are not certified, are you eligible? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If yes, Exam date: | |
| Subspecialty: | | Board Certified? Yes <input type="checkbox"/> No <input type="checkbox"/> | If you are not certified, are you eligible? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If yes, Exam date: | |
| CAQH ID: | | National Provider Identifier (NPI): | | License #: | | DEA #: |
| Provider Category: PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both <input type="checkbox"/> Hospital Only <input type="checkbox"/> Moonlighter/Covering <input type="checkbox"/> | | Primary Hospital Affiliation & Staff Position: | Secondary Hospital Affiliation & Staff Position: | Other Affiliations: | If no hospital affiliation, provide admitting arrangements and MD name: | |

Nurse Practitioner Board Certificate Number: _____ Provide collaborating MD for all NP's, PA's and APRN's: _____
 Some emergency medicine, radiologists, anesthesiologists, or pathologists who practice exclusively within a facility and who do not receive direct referrals may qualify for an abbreviated process. Please check here if you meet the criteria.

Section 2: Primary Practice Information

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group. Use last page to list additional addresses.

| | | | |
|---|-------|----------------------------|-----------------------------------|
| Practice Name: _____ | | | |
| Is this your Mailing Address? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If no, complete last page. | |
| Is this your Credentialing Address? Yes <input type="checkbox"/> No <input type="checkbox"/> | | If no, complete last page. | |
| Can patients make an appointment at this location? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, include this address in health plan directories? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If yes, do you offer both in person & telehealth/virtual visits? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| If no, do you offer Telehealth <u>only</u> services (no in person visits)? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| Primary Address: | | | |
| Street | | | |
| City | State | Zip Code | Languages spoken by office staff: |

Appointment Scheduling Telephone: _____ FAX: _____ Practice Email: _____ Practice Manager Name: _____ Practice Start Date: _____

Office Hours:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes No

Handicap Access: Yes No

Practice Type: Solo Partnership Single Specialty Group Multi-Specialty Group Concierge Model Other: _____

Does this office location use an Electronic Medical Record? Yes No

Does this office offer E-prescribing? Yes No

Section 3: Payment Information

| | | | | |
|--------------------------|-----------|---------------------------------|----------------|-------------------|
| Payee Name: _____ | | Tax Identification Number _____ | | Group NPI # _____ |
| Payment Address | | | | |
| Street _____ | | | | |
| City _____ | | State _____ | ZIP Code _____ | Email _____ |
| Telephone _____ | Fax _____ | Contact Name _____ | | |

Section 4: Other Provider Information

What is the provider's status? Accepting new patients Accepting existing patients only Closed (not accepting new patients)

What age groups does the provider treat?

Does the provider participate in and meet the conditions of participation in Medicare? Yes No

Does the provider have a current, valid and active Medicare participating PTAN number? Yes No

If yes, please indicate participating individual PTAN number:

Please indicate individual Medicaid number:

Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes No

Describe the steps you take to monitor for and prevent discriminatory practices:

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Additional Documents to Submit: Please see *Health Plan Contracting and Enrollment Required Documents List* located on the Credentialing Resources page at www.hcasma.org.

Section 5: Submission Information

| | | |
|---|---|--|
| Blue Cross Blue Shield of MA Fax: 617-246-4227 Phone: 800-316-BLUE (2583) Email: NetworkManagement@bcbsma.com | Fallon Health 1 Mercantile St., Suite 400 Worcester, MA 01608 Fax: 508-368-9902 Provider Services: 866-275-3247, prompt 4 Email: providerdataupdates@fallonhealth.org | Harvard Pilgrim Health Care Attn: Provider Processing Center Fax: 866-884-3843 Email: PPC@point32health.org |
| Health New England One Monarch Place, Suite 1500 Springfield, MA 01144 Fax: 413-233-3175 Phone: 800-842-4464 Provider Contracting Email: PContracting@HNE.com | Mass General Brigham Health Plan Credentialing Department 399 Revolution Drive, Suite 820 Somerville, MA 02145 Provider Service Center: Fax: 617-526-1982 Phone: 855-444-4647 Email: HealthPlanPEC@mgb.org | Tufts Health Plan/Tufts Health Public Plans Attn: Provider Enrollment Fax: 617-972-9591 Email: Provider_Information_Dept@point32health.org |
| WellSense Health Plan Provider Processing Center 100 City Square, Suite 200 Charlestown, MA 02129 Fax: 617-897-0818 Provider Processing Center: 888-566-0008 Email: providerprocessingcenter@wellsense.org | | |

Additional Practice Location

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group

Practice Name:

Additional Practice Mailing Address Credentialing Address
 Can patients make an appointment at this location? Yes No
 If yes, include this address in health plan directory? Yes No
 If yes, do you offer both in person & telehealth/virtual visits? Yes No
 If no, do you offer Telehealth only services (no in person visits)? Yes No

Address:

Street _____

 City State ZIP Code Languages Spoken by office staff

Appointment Scheduling Telephone: Fax: Practice Email: Practice Manager Name: Practice Start Date:
 Telephone:

Optional Practice Information

Office Hours:

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes No

Handicap Access: Yes No

Practice Type: Solo Partnership Single Specialty Group Multi-Specialty Group Concierge Model Other:

Does this office location use an Electronic Medical Record? Yes No

Does this office offer E-prescribing? Yes No