# H:\HCAS\logo designs\final files\zip files from Somani\FinalLogoFiles\H6(WhiteBG)\H6(WhiteBG).jpg  *Provider Enrollment Form*

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|      |        |        |        |
| **DATE** | **COMPLETED BY** | **TELEPHONE** | **EMAIL OF PERSON COMPLETING FORM** |

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| Section 1: Provider Information |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|       |     |       |       |       |       | M [ ]  F [ ]  Non-Binary [ ]  |
| 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 [ ]  No [ ]  If you are not certified, are you eligible? Yes [ ]  No [ ]  If yes, exam date:      |
| **Subspecialty:**       | Board Certified? Yes [ ]  No [ ]  If you are not certified, are you eligible? Yes [ ]  No [ ]  If yes, exam date:      |
| CAQH ID:       | National Provider Identifier (NPI):       |  License #        | DEA #:       |
| PCP [ ]  Specialist [ ]  Both [ ] Hospitalist Only [ ]  Moonlighter/Covering [ ]  |       |       |       |       |
| Provider Category Primary Hospital Affiliation Secondary Hospital Affiliation Staff Position 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. [ ]  Will you be billing independently or through a collaborating provider? Ind [ ]  CP [ ]   |

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| 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: |  |
| **Primary Address:** | Can patients make an appointment at this location? Yes [ ]  No [ ]  If yes, include this address in health plan directory? Yes [ ]  No [ ]  If no, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is this your Mailing Address Yes [ ]  No [ ]  If no, complete last page.Is this your Credentialing Address Yes [ ]  No [ ]  If no, complete last page. |
|  |
| Street |
|        |        |        |        |
| City | State | ZIP Code | Languages Spoken by office staff |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Telephone:      | Fax:       | Practice Email:       | Practice Manager Name       | Practice Start Date       |
|  |

Office Hours:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|        |        |        |        |        |        |        |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

Average Waiting Time to Schedule:

|  |  |  |
| --- | --- | --- |
|        |        |        |
| Initial Visit | Routine Physical | Urgent Visit |

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 the provider offer telehealth? Yes [ ]  No [ ]

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| 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 and not accepting existing patients)

What age groups does the provider treat?

Please list any practice restrictions for the provider:

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:

|  |
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| 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**](http://www.hcasma.org)**.**

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| 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 One Chestnut Place10 Chestnut StreetWorcester, MA 01608**Fax:** 508-368-9902**Provider Services:** 866-275-3247, prompt 4**Email:** providerdataupdates@fallonhealth.org | Harvard Pilgrim Health CareAttn: Provider Processing Center**Fax:** 866-884-3843**Email:** PPC@point32health.org |
| Health New EnglandOne Monarch Place, Suite 1500Springfield, MA 01144**Fax:** 413-233-3175**Phone:**  800-842-4464**Provider Contracting Email**: PContracting@HNE.com | Mass General Brigham Health PlanCredentialing Department399 Revolution Drive, Suite 820Somerville, MA 02145**Provider Service Center:****Fax:** 617-526-1982**Phone:** 855-444-4647**Email:** HealthPlanPEC@mgb.org  | Tufts Health PlanAttn: Provider Operations**Email:** Provider\_Information\_Dept@point32health.org |
| Tufts Health Public PlansAttn: Provider Information**Provider Information Email:**Provider\_data\_request@point32health.org | **WellSense Health Plan**Provider Processing Center529 Main Street, Suite 500Charlestown, MA 02129**Fax:** 617-897-0818**Provider Processing Center:** 888-566-0008**Email:** providerprocessingcenter@wellsense.org |  |

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| --- |
| 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 no, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address:** |  |
|  |
| Street |
|        |        |        |        |
| City | State | ZIP Code | Languages Spoken by office staff |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Telephone:      | Fax:       | Practice Email:       | Practice Manager Name       | Practice Start Date       |
|  |
|  Optional Practice Information |

Office Hours:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|        |        |        |        |        |        |        |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

Average Waiting Time to Schedule:

|  |  |  |
| --- | --- | --- |
|        |        |        |
| Initial Visit | Routine Physical | Urgent Visit |

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 the provider offer telehealth? Yes [ ]  No [ ]

|  |
| --- |
| Additional Practice Location |

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

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| --- | --- |
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|  | 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 no, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Address:** |  |
|  |
| Street |
|        |        |        |        |
| City | State | ZIP Code | Languages Spoken by office staff |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Telephone:      | Fax:       | Practice Email:       | Practice Manager Name       | Practice Start Date       |
|  |
|  Optional Practice Information |

Office Hours:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|        |        |        |        |        |        |        |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |

Average Waiting Time to Schedule:

|  |  |  |
| --- | --- | --- |
|        |        |        |
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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 the provider offer telehealth? Yes [ ]  No [ ]