# 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 |

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|  |  |  | |  |  | | | | |  | 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 |

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| 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:

|  |  |  |
| --- | --- | --- |
| 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](mailto:NetworkManagement@bcbsma.com) | Fallon Health  One Chestnut Place  10 Chestnut Street  Worcester, MA 01608  **Fax:** 508-368-9902  **Provider Services:** 866-275-3247, prompt 4  **Email:** [providerdataupdates@fallonhealth.org](mailto:providerdataupdates@fallonhealth.org) | Harvard Pilgrim Health Care  Attn: Provider Processing Center  **Fax:** 866-884-3843  **Email:** [PPC@point32health.org](mailto: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](mailto: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](mailto:HealthPlanPEC@mgb.org) | Tufts Health Plan  Attn: Provider Operations  **Email:** [Provider\_Information\_Dept@point32health.org](mailto:Provider_Information_Dept@point32health.org) |
| Tufts Health Public Plans  Attn: Provider Operations**Provider Information Email:** [Provider\_Information\_Dept@point32health.org](mailto: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](mailto: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

|  |
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| Additional Practice Location |

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| **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:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
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Does the provider offer telehealth? Yes  No