Ancillary Contracting and Credentialing Information Form

Point32Health

Harvard Pilgrim Health Care TUFTS Health Plan

This application is specific to non-behavioral health providers.
For BH please reference this form.

Point32Health, the parent organization of Harvard Pilgrim Health Care and Tufts Health Plan, requires information about your facility/ organization in order to fully evaluate your application to become a participating provider and join our network.

Accreditation and certification information

Please include accreditation certificate information and license (**when applicable**).

Please select applicable plans for which you wish to join our network(s)

Harvard Pilgrim Health Care

Please submit to our Provider Processing Center at ppc@point32health.org.

- ☐ Harvard Pilgrim Health Care Commercial Products

Tufts Health Plan

Please submit to AncillaryNetworkContracting@point32health.org.

- ☐ Tufts Health Public Plans: ☐ Tufts Health Direct ☐ Tufts Health RITogether ☐ Tufts Health Together ☐ Tufts Health One Care
- ☐ Tufts Health Senior Products: ☐ Tufts Medicare Preferred ☐ Tufts Health Plan Senior Care Options (SCO)

Required credentialing documentation

To ensure your application is processed in a timely fashion, please attach the following required documentation, in addition to this completed form:

- ☐ A completed and signed W-9 Form
- ☐ Copy of state license (*if applicable*)
- ☐ Copy of Accreditation Certification or State site visit within the last three years (*if not accredited*)
- ☐ A Federally Required Disclosures Form (*applicable to MA & RI only*)
  Note: *Although a MassHealth form, it can be completed for both MA & RI Facilities*
- ☐ Radiology Only: copy of the state issued Radiation Control Program Certificate or Clinic license
- ☐ Laboratory Only: copy of state license and copy of CLIA certificate

Accreditation

If your facility is accredited:

- ☐ Copy of the most recent accreditation certificate which includes the effective date and expiration date (e.g., The Joint Commission (TJC), The Commission on Accreditation of Rehabilitation Facilities (CARF), Community Health Accreditation Program (CHAP), Urgent Care Association of America (UCAOA), etc.)
- ☐ Also provide the following, if applicable, to your accreditation status:
  - ☐ Decision report/letter
  - ☐ Written progress report
  - ☐ Letter from accreditation agency removing any corrected recommendations/deficiencies (*if applicable*)

If your facility is NOT accredited:

- ☐ Provide the most recent Department of Public Health (DPH/CMS) survey report, (must be within 3 years, if applicable to your survey status)
- ☐ Follow-up letter of acceptance from the DPH (for corrective action plans) or in lieu of the survey report, a letter from the DPH or applicable state agency which shows that the facility was reviewed and indicates that all deficiencies have been corrected and it passed inspection

For more information, access the Harvard Pilgrim Health Care Required Credentialing Documentation or Tufts Health Plan Required Credentialing Documentation.

Facility/organization specialty (*please check all that apply*)

- Acute Rehabilitation Facility*
  - LTAC (Long term Acute Care)
  - IRF (Inpatient Rehabilitation Facility)
- Ambulance Service
  - Wheelchair
  - Emergent
  - Non-emergent
- Ambulatory Surgical Center*
- Assisted Reproductive Therapy (ART)/IVF*
- Audiology Group+
- Cardiac Rehabilitation Services
- Chiropractic Group+
- Dialysis*
- DME
  - Customized Equipment
  - Manufacturer of Medical Supplies
  - Medical Supplies
  - Oxygen and Respiratory Equipment
  - Orthotic/Prosthetic Supplies
  - Wig
- Early Intervention
- Home Care#
- Home Infusion*
- Hospice*
- Laboratory/Genetics*
- Occupational Therapy Group*
- Physical Therapy Group*
- Radiology/Diagnostic Imaging Facility*
  - CT
  - MRI
  - PET
  - Ultrasound
- Registered Dietician Group+
- Skilled Nursing Facility*
- Sleep Laboratory*
- Speech Therapy Group*
- Urgent Care*
- Other (*specify*):

* *require credentialing*

\+ *Please note, individual practitioners must complete an HCAS form and submit a credentialing application at proview.caqh.org.*

\# *Providers must be enrolled as a Home Health Agency in order to bill for Continuous Skilled Nursing services*

If you have additional physical locations, please attach a separate list including address, phone, contact name, TIN, NPI and Medicare Certification Number for each location.

Facility/organization information

Physical location (*address where services are rendered, if applicable*)

Facility name

Street Suite

City, State, ZIP

Phone (*this will be used in the Provider Directory*) Fax

Email Website

Contact (*name, title and email address*)

Service hours: Mon Tue Wed Thu Fri Sat Sun

Handicap access? Yes No

American with Disabilities Act (ADA) compliance (*please check all that apply*)

- Staff receives ADA-compliance training
- Facility can accommodate people who are physically disabled (e.g., accessible parking, wheelchair access to building)
- Facility allows wheelchair access to exam rooms
- Facility can accommodate people who are intellectually/cognitively disabled (e.g., on-site staff to explain instructions)
- Facility can accommodate people who are blind or visually impaired (e.g., service animals allowed, Braille directions available)
- Facility can accommodate people who are deaf or hard of hearing (e.g., American Sign Language or written instruction available)
- Facility is accessible by public transportation (e.g., bus, subway or commuter rail)

Are translation services available? Yes No

Languages other than English at this location:

Facility Tax ID# Facility Medicare PTAN# (used to bill Medicare claims)

NPI# **Facility Medicaid certification #**

Does your facility bill under any other Tax ID or NPI numbers: Yes No
(*if Yes, please attach a separate list of numbers, payment names and addresses*)

Legal notice address (*Who is responsible for legal notices?*)

Legal business name

Title of person who notices should be addressed to

Street Suite

City, State, ZIP

Phone Email

Contact *(name, title and email address)*

Signatory authority

To allow us to draft the agreement with the current information, please provide the name and title of the person authorized to execute (sign) the Point32Health agreement.

Please print the **name** of the person authorized to sign the Agreement:

Please print the **title** of the person authorized to sign the Agreement:

Payment/remittance address

Payment name (*name should appear exactly as on 1099 forms and claim forms*)

'Remit to' street Suite

City, State, ZIP

Phone Fax

Ambulatory surgical center (ASC)

Please indicate what type of procedures are performed at your ASC (e.g., orthopedic, endoscopy, colonoscopy, eye, etc.)

Please attach a list of the physicians/clinicians who provide anesthesia, laboratory, pathology, and/or radiology services referred to or provided in conjunction with your operation (please provide name, address, TIN, NPI, and phone number). These physicians/clinicians must participate in the Point32Health network.

Long-term services and supports (LTSS)

Tufts Health Plan requires information about your facility/organization in order to fully evaluate your application to become a participating LTSS provider and join our network. Please complete the LTSS Provider Attestation form and this section.

Does your organization offer LTSS coordination? ☐ Yes ☐ No

If *Yes*, the number of long-term support coordinators available?

LTSS organization type?

☐ Aging services access point (ASAP) ☐ Independent living center (ILC) ☐ Recovery learning community (RLC)

Credentialing (*Who is responsible for credentialing questions and future recredentialing outreach?*)

Name Title

Mailing address: Street Suite

City, State, ZIP

Phone Fax Email

Statement of understanding

I hereby certify that the information given in the enclosed document is accurate. I shall immediately forward to Point32Health written notification of any modifications, corrections or changes to such information.

The facility agrees to provide ongoing recredentialing data as requested by Point32Health.

Signature:

Print name and title:

Facility name: Date:

CLEAR FORM

This document is confidential and must not be disclosed to any third party without prior written consent of Point32Health.