Point32Health

Harvard Pilgrim Health Care TUFTS Health Plan

Letter of Intent

The purpose of the Letter of Intent is to assist Point32Health in assessing your candidacy as a participating provider. Along with this Letter of Intent, you must also complete and submit an HCAS Provider Enrollment form for each practitioner.

Your letter should include:

1. Legal entity name (i.e. group name) and the following:
    - Signatory name and title, email address, and telephone number (if a group agreement is being requested, the signatory must have the authority to sign on behalf of the providers/group).
2. Primary contact name, telephone number, and email address for questions related to this agreement. This is the individual/contact to whom we will send next steps, including but not limited to an Agreement for signature.
3. Board specialty additional information
    - For primary care specialty: Will you hold a panel? If you will not be holding a panel, please explain why you are requesting to become a participating provider.
    - For NP/PA: please review our Advance Practice Providers Payment Policy. Will you be billing under your supervising MD or under your NPI as the servicing provider? Are you trained/certified in areas of family practice, gerontology, adult, and pediatrics and intend to contract as a PCP and hold a panel? If not, please explain why you are requesting to become a participating provider
4. Description of services
    - Provide an overview of the services you will provide
    - Provide the CPT codes billed in your practice
5. Reason for requesting a contract with Point32Health, including how your practice increases access and availability of medical services within your community.
6. Practice demographics (all the following required):
    - Physical address(es) where members will receive in-person care
    - Telephone number for members to make appointments/ask questions
    - Provider office/group website
7. Tax Identification Number (the payee TIN)
    - Pay-to name
    - Group NPI

Note: Point32Health requires the use of participating providers for any diagnostic tests ordered.

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I hereby certify/attest 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. I understand that Point32Health may share this document with federal or state regulators and/or provider/agency partner organizations. Any misrepresentation or omission will be sufficient cause for immediate, unilateral termination by Point32Health Entity of any Point32Health Entity provider agreement.

Name: ______________________________________

Title: ____

Email: _______________________________________

Telephone: ___________________________________

This is not an Agreement and submitting this information does not guarantee that Point32Health will send an Agreement. The information provided will be reviewed and you will receive information regarding next steps as appropriate, including, but not limited to, credentialing and the sending of an Agreement for signature. Such Agreement will not be effective until countersigned by the applicable Point32Health entity, which will include the effective date upon when you will be considered credentialed, contracted, and able to see members as a participating provider. We reserve the unqualified right to reject any and all participation requests.