

# Provider Information Form: Medical Providers/Community Based Organization

Complete **all** sections and email the completed form to [Provider\\_Information\\_Dept@point32health.org](mailto:Provider_Information_Dept@point32health.org).

Today's date     /     /     Contact name

Phone     Email

## Type of information *(check all that apply)*

### **Tufts Health Plan Commercial**

*(We are not accepting new providers into the Tufts Health Plan Commercial network, except in instances where the provider is joining a currently participating practice).*

### **Tufts Health Public Plans Products**

*(Tufts Health Direct, Tufts Health Together, Tufts Health One Care, and Tufts Health RITogether)*

### **Tufts Health Senior Products**

*(Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options [SCO])*

## Check one of the following provider types:

New individual provider or provider group     Current individual provider or provider group

New hospital or facility     Current hospital or facility

Provider ID # or billing ID #

Tax ID #

## Type of information being changed/added *(check all that apply)*

New provider profile     New provider profile for existing group     Add information to existing profile     Add practice address

Change existing practice address     Change existing billing address     Change panel status     Change group affiliation

Add billing address (attach W-9)     Change existing name     Add group affiliation

Effective date for change/addition     /     /

Terminate provider profile     Provider termination effective date     /     /

## Reason for termination:

Left group practice     Moved out of state     Retired     PCP changed to specialist     Changed tax ID #

Practice closed     Deceased     Other

## Section A: Provider information

Last Name     First Name     M.I.

Suffix (e.g., MD, DO, PA, NP)     Sex:     M     F     DOB     /     /

SSN     DEA #

MA lic #     NPI # *(if applicable)*

Medicare ID #     CAQH ID #

Is the provider contracted with MassHealth (Medicaid)?     Yes     No

Medicaid ID # *(if applicable)*     IPA/PHO affiliations

Email     Phone

Primary Specialty     Board-certified     Board-eligible

Secondary Specialty     Board-certified     Board-eligible

Certified Suboxone prescriber provider?     Yes; Certification #     No

## Section B: Practice information

**Practice location (location 1)** Complete the following for the practice location of the provider in Section A.

Practice name

Practice address

City/State/ZIP

Country

Secure fax

Phone

Practice email

Practice website

Practice contact name

Group Affiliation (if applicable)

Practice NPI #

Office Hours: Sun Mon Tue Wed Thu Fri Sat

Operational 24/7? Yes No Extended hour available? Yes No Home visits available? Yes No

Age groups seen: 0-18 19-64 65+ Home visits available? Yes No

Is the provider a practicing PCP at this location? Yes No

Available to see new members: Yes No Available to see new members with a waitlist of 4 weeks or less: Yes No

Are you currently utilizing interoperable Electronic Health Records? Yes No

(certified by Office of the National Coordinator, 2015 Edition Cures Update)

**Practice location (location 2)** Include only addresses with the same tax ID # as location 1.

Practice name

Practice address

City/State/ZIP

Country

Secure fax

Phone

Practice email

Practice website

Practice contact name

Group Affiliation (if applicable)

Practice NPI #

Office Hours: Sun Mon Tue Wed Thu Fri Sat

Operational 24/7? Yes No Extended hour available? Yes No Home visits available? Yes No

Age groups seen: 0-18 19-64 65+ Home visits available? Yes No

Is the provider a practicing PCP at this location? Yes No

Available to see new members: Yes No Available to see new members with a waitlist of 4 weeks or less: Yes No

**Long-term services and supports (LTSS)** Complete all information that applies to your practice.

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)

**Facility-specific information** Provide all information that applies to your facility.

Facility Medicaid certification #

Number of Medicaid beds?

Facility Medicare certification #

Critical care/Intensive care unit

Inpatient behavioral health

Acute care hospital

Skilled nursing facility

Is hospital/facility a licensed facility through the Massachusetts Department of Public Health?

Yes; Licensure #

No

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

Staff receives ADA-compliance training

Practice can accommodate people who are physically disabled (e.g., accessible parking, wheelchair access to building)

Practice allows wheelchair access to exam rooms

Practice can accommodate people who are intellectually/cognitively disabled (e.g., on-site staff to explain instructions)

Practice can accommodate people who are blind or visually impaired (e.g., service animals allowed, Braille directions available)

Practice can accommodate people who are deaf or hard of hearing (e.g., American Sign Language or written instruction available)

Practice is accessible by public transportation (e.g., bus, subway or commuter rail)

**Section C: Covering provider information** Note: Complete if for PCPs only.

Last Name

First Name

M.I.

Suffix (e.g., MD, DO, PA, NP)

Sex: M F

Address

City/State/ZIP

NPI # (if applicable)

Tax ID #

Separately attach all of the above information for any additional covering providers.

Do providers cover for each other? Yes No

**Section D: Billing information** Submit a W-9 for each new billing address if there are additional billing addresses.

Tax ID #

For this Tax ID #, which claim form(s) will you use? Check one: UB04 CMS1500 Both

Name on check Check one: Individual name Group name

Address

City/State/ZIP

Send 1099 to this address

This is an EDI address

Send payments to this address

This is a new billing address

Do you currently receive payments from us by electronic funds transfer (EFT)? Yes No

If not, are you interested in receiving EFT payments? Yes No

**Section E: IRS – 1099 address** Submit a W-9. Note: Legal name must match IRS records.

1099 legal name

1099 legal address

City/State/ZIP

**Section F: Attestation**

I hereby certify that the above information is accurate and complete. I understand that Tufts Health Public Plans is relying on my certification to make submissions to state and federal regulators and to distribute information to members, and that submission of inaccurate information may result in contract termination and legal action.

Provider Signature

Date / /

Provider name (please print)