Provider Information Form: Medical Providers/Community Based Organization

TUFTS Health Plan
a Point32Health company

Complete **all** sections and email the completed form to 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

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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

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

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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*)

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