

# Ancillary Data Form Community Mental Health Center/ Substance Use Treatment Center/ ABA Services

Please use this checklist as a guide when completing the requirements to become a participating provider with Harvard Pilgrim Health Care/Tufts Health Plan.

## Please select applicable plans for which you would like to be credentialed:

**Harvard Pilgrim Health Care** – Please return this document, along with the other contracting materials provided, to our Provider Processing Center at [ppc@point32health.org](mailto:ppc@point32health.org) or by fax to 866-884-3843.

Harvard Pilgrim Health Care Commercial products

**Tufts Health Plan** – Please email the completed application to [Provider\\_Information\\_Dept@point32health.org](mailto:Provider_Information_Dept@point32health.org) or fax to 617-972-9591. To facilitate review of your application, please return all materials together.

Tufts Health Public Plans Massachusetts products

Tufts Health RITogether

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

Please note that, consistent with state requirements, Rhode Island providers requesting to join our commercial network must also become participating providers in our Rhode Island Medicaid network for the Tufts Health RITogether product.

## Provider Eligibility Criteria

Organizations licensed by the state as Behavioral Health Clinics are eligible to apply for consideration as contracted behavioral health care providers for Harvard Pilgrim Health Care/Tufts Health Plan.

## Required Credentialing Documentation

A completed Ancillary Data Form Community Mental Health Center/Substance Use Treatment Center Application

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

## Accreditation\*

### If your facility is accredited:

Copy of the most recent accreditation certificate which includes the effective date and expiration date i.e.: TJC (aka The Joint Commission), CARF, CHAP, UCAOA (Urgent Care Association of America) 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)

\* ABA Services must be accredited. Accreditations accepted are Behavioral Health Center of Excellence (BHCOE) and Autism Commission on Quality (ACQ).

### If your facility is NOT accredited:

Provide the most recent applicable state survey report, DPH, CMS or Department of Mental Health (DMH)

Follow-up letter of acceptance from the DPH/DMH (for corrective action plans) or in lieu of the survey report, a letter from the DPH/DMH or applicable state agency which shows that the facility was reviewed and indicates that all deficiencies have been corrected and it passed inspection

## Insurance

The clinic must maintain professional liability insurance in the amount of \$1 million per incident, and \$3 million in the aggregate per year covering all clinicians included in the agreement.

## Articles of Incorporation

A copy of the Clinic's Articles of Incorporation or similar documents submitted to the state or local authorities in order to register the group with appropriate governmental units.

## General Information *Missing information will delay your application*

Contract/Legal Entity Name

DBA/Practice Name *(if applicable)*

NPI

Type of Provider      Community Mental Health Center      Substance Use Treatment Center      ABA Service Provider

Participating in Medicare? YES      ; Medicare PTAN #      NO

Participating in MassHealth/Medicaid? YES      ; MassHealth ID      NO

Participating in Rhode Island Medical Assistance Program (Medicaid)? YES      ; ID      NO

### Primary Practice address

Phone

Street      City, State, ZIP

Fax

Email

Service hours: Mon      Tue      Wed      Thu      Fri      Sat      Sun

Handicap access? YES      NO

Are translation services available? YES      NO

Languages other than English at this location

### Secondary Practice address

Phone

Street      City, State, ZIP

Fax

Email

Service hours: Mon      Tue      Wed      Thu      Fri      Sat      Sun

Handicap access? YES      NO

Are translation services available? YES      NO

Languages other than English at this location

Check here for additional addresses and attach a separate sheet.

## Mailing Information *Corporate affiliated providers with different names and locations need to submit separate applications.*

### Mailing address

Phone

Street      City, State, ZIP

Fax

### Corporate Affiliation *(if different)*

Phone

Street      City, State, ZIP

Fax

Managed by

*Please explain in detail any name changes that have occurred in the past 3 years and attach appropriate documentation:*

## Practice Information

President/CEO

Office Mgr/Contact person

*Please provide the contact information for the person we should contact if we have any questions about the information on this form.*

Phone      Fax      Email

## Payment Information

Payee NPI      Tax ID#      -

To whom should checks be made payable?

### Payment address

Phone

Street      City, State, ZIP

Fax

*Please enclose a copy of your W-9 form (request for taxpayer ID). Payee name and tax ID# must match information on your W-9.*

**Special populations served** *Check all that apply*Patients who are:

Adolescents	Geriatrics
Adults	Homelessness
Child welfare	Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
Children	Military and veterans
Children or child in care of or custody of DCF (Department of Children and Families)	Youth affiliated with DYS (Department of Youth Services) either detained or committed

**Attributes and Modalities of Care** *Check all that apply*Treatment options:

Cognitive Behavioral Therapy (CBT)	Neuropsychological Testing (Children)
Dialectical Behavioral Therapy (DBT)	Play Therapy
Group Therapy	Postpartum Depression and/or Psychosis
Marriage and Family Therapy	Prolonged Exposure
Medical Illness Therapy	Psychological Testing (Adults)
Medication Management and Therapy	Psychological Testing (Adolescents)
Neuropsychological Testing (Adults)	Psychological Testing (Children)
Neuropsychological Testing (Adolescents)	Transcranial Magnetic Stimulation (TMS)

Physical conditions:

Blindness or visual impairment  
Deafness or hard of hearing  
People with disabilities  
Physical disabilities

**Areas of Expertise** *Check all that apply*

Adoption	Fire setting	Race based trauma
Anger management	Foster care	Schizophrenia
Anxiety	Gender identity disorder	Serious mental illness
Attention-deficit/hyperactivity disorder (ADHD)	Geriatric behavioral health	Sexual abuse/rape trauma
Autism spectrum disorders	Grief counseling	Sexual dysfunction
Bipolar disorder	HIV/AIDs	Sexual offenders
Brain injury	Infertility	Sleep disorders
Chronic illness	Learning disabilities	Substance use
Compulsive gambling	Methadone maintenance	Suicide prevention
Co-occurring disorders	Mood disorders	Transgender
Crisis intervention	Obsessive-compulsive disorder (OCD)	Trauma
Depression	Personality disorders	
Developmental disabilities	Phobic disorders	
Eating disorders	Post-traumatic stress disorder (PTSD)	

**Levels of Care Provided** *Check all that apply*

Applied Behavioral Analysis Services (ABA)	Medication Assisted Treatment (MAT)
In Home	Methadone Treatment
Center Based	Outpatient Behavioral Health Program
Community Behavioral Health Center	Outpatient Detoxification Program
Dual Diagnosis Intensive Outpatient Program	Psychiatric Intensive Outpatient Program
Dual Diagnosis Partial Hospitalization Program	Psychiatric Partial Hospitalization Program
Early Intensive Behavioral Intervention (EIBI)	Residential Rehabilitation Services (RRS) ASAM Level 3.1
Eating Disorder Intensive Outpatient Program	Substance Use Disorder Intensive Outpatient Program
Eating Disorder Partial Hospitalization Program	Substance Use Disorder Partial Hospitalization Program
Electroconvulsive Therapy (ECT)	Therapeutic Mentoring for Children and Adolescents
Family Support and Training (FS&T) for Children and Adolescents	
In-Home Behavioral Services for (IHBS) Children and Adolescents	
In-Home Therapy (IHT) for Children and Adolescents	
Intensive Care Coordination (ICC) for Children and Adolescents	

**Americans with Disabilities Act 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/visually impaired (e.g. service animals allowed, Braille directions available)  
Practice can accommodate people who are deaf/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)

## CERTIFICATION, AUTHORIZATION AND RELEASE

Contract/Legal Entity Name

DBA/Practice Name (if applicable)

In submitting this application for credentialing (or recredentialing) by Harvard Pilgrim Health Care (collectively "Plan") / Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., or any Tufts Health Plan affiliate (as defined in your written agreement to provide services to Tufts Health Plan members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. Certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.
3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

Authorized Representative's Signature

Date

/ /

Authorized Representative's Name (Please Print)

Authorized Representative's Title