PROVIDER APPLICATION

MEDICAL PRACTITIONER

Application Tracking #

Print | Clear

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

This application will not be processed if any sections are left unanswered.

CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS APPLICATION (MassHealth may contact you if there are questions about this application.)

Name	Tel. #	–	–
E-mail			

SECTION 1: APPLICANT INFORMATION

1.1 APPLICATION TYPE

Is the applicant enrolling as: ☐ an individual practitioner practicing independently ☐ Part of a group practice organization ☐ Both

Does the applicant wish to participate in the Primary Care Clinician (PCC) Plan? ☐ Yes ☐ No

Note: The following provider types can enroll as PCCs: Physician (PT01), Certified Nurse Practitioner (PT17), Physician Assistant (PT 39) (Must be part of a group practice organization with at least one physician). PCC qualifying providers (or in the case of physician assistants, their supervising physician in their group practice organization) must specialize in: Family Medicine, Internal Medicine, Pediatrics, Ob/GYN or GYN and otherwise satisfy PCC Plan participation requirements.

Note: This application is for individual practitioners of the provider types listed below, who practice independently or as part of a group practice, and who wish to enroll as a participating MassHealth practitioner. This application should not be completed by other salaried or contracting providers. Please indicate your provider type below.

- ☐ Physician (PT01)
- ☐ Optometrist (PT02)
- ☐ Optician (PT03)
- ☐ Ocularist (PT04)
- ☐ Psychologist (PT05)
- ☐ Podiatrist (PT06)
- ☐ Certified Nurse Midwife (PT08)
- ☐ Chiropractor (PT16)
- ☐ Certified Nurse Practitioner (PT17)
- ☐ Physician Assistant (PT39) (Must be a part of a Group Practice Organization with at least one Physician)
- ☐ Hearing Instrument Specialist (PT44)
- ☐ Audiologist (PT50)
- ☐ Certified Registered Nurse Anesthetist (PT51)
- ☐ Clinical Nurse Specialist (PT57)
- ☐ Psychiatric Clinical Nurse Specialist (PT78)
- ☐ Qualified Medicare Beneficiary (PT86) (QMB)-Only Providers (cannot be part of a group)

1.2 APPLICANT INFORMATION

Legal Name of Applicant (Last, First, Middle Initial)	
☐ Individual (SSN)	☐ Sole Proprietor (SSN or EIN)
Applicant's National Provider Identification (NPI)	
Primary Taxonomy Code (optional)	Applicant's Professional License Number (MA)
State/License Number	State/License Number
☐ DEA Number (if issued)	☐ Check box if prescribing only Schedule VI drugs

Legal/Home Address	Building, Suite, or P.O. Box (if applicable)
City	State / Zip
ATTN/Title:	E-mail
Tel. # – –	Fax # – –

1.3 MEDICAID INFORMATION FOR OTHER STATES

Does the applicant currently participate, or has he or she previously participated, in another state's Medicaid program? ☐ Yes ☐ No

List Other State	Medicaid Number
Effective Date	End Date (if applicable)
List Other State	Medicaid Number
Effective Date	End Date (if applicable)
List Other State	Medicaid Number
Effective Date	End Date (if applicable)

1.4 CERTIFIED SPECIALTY

Primary Certified Specialty (as certified by your board of professional licensure)

Other Specialty (if applicable)	Other Specialty (if applicable)

1.5 MEDICARE INFORMATION

Is the applicant enrolled in Medicare as a provider? ☐ Yes ☐ No

Medicare participation is required for certain provider types. Please refer to MassHealth's all-provider regulations and all applicable program-specific regulations. You can access these publications from the MassHealth website at www.mass.gov/eohhs/gov/laws-regs/masshealth/.

SECTION 2: INDIVIDUAL PRACTITIONER PRACTICING INDEPENDENTLY

Note: This section applies ONLY to individual practitioners practicing independently and practitioners BOTH practicing individually AND as part of a group practice organization. If applying to participate ONLY as part of a group practice organization, please proceed to Section 3.

2.1 BILLING AGENT INFORMATION

Please indicate how the applicant will be submitting electronic claims (with limited exceptions, MassHealth does not accept paper claims (see 130 CMR 450.302)).

☐ Submit electronic claims directly. ☐ Submit electronic claims through a billing intermediary.

Billing Agent Name	MassHealth Relationship Entity Number

(Note: Billing agents must apply for a relationship entity number before they can submit claims on behalf of the applicant. For more information, contact the MassHealth Customer Service Center by e-mail at providersupport@mahealth.net or call 1-800-841-2900.)

Billing Agent Tel. # – –

2.2 BILLING ADDRESS

Is the billing address the same as the legal address in Section 1.2? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.2.

Number / Street		Building, Suite, or P.O. Box if applicable	
City	State	Zip	–
ATTN/Title:		E-mail	
Tel. #	– –	Fax #	– –

2.3 CORRESPONDENCE MAILING ADDRESS (FOR NOTICES, UPDATES, ETC.)

Is the correspondence address the same as the legal address in Section 1.2? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.3.

Is the correspondence address the same as the billing address in Section 2.2? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.3.

Number/Street		Building, Suite, or P.O. Box if applicable	
City	State	Zip	–
ATTN/Title		E-mail	
Tel. #	– –	Fax #	– –

2.4 SERVICE LOCATION (SL) INFORMATION/ "DOING BUSINESS AS" (DBA) NAME

Enter the applicant's trade (SL/DBA) name, street address, and all other information requested below that is applicable to this service location (SL) where services will be provided to MassHealth members. Post office box addresses are not acceptable. Enrollment will not be approved if only a post office box address is entered in this space.

Is the SL address the same as the legal address in Section 1.2? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.4.

Is the SL address the same as the billing address in Section 2.2? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.4.

Is the SL address the same as the correspondence address in Section 2.3? ☐ Yes ☐ No
If "Yes," you do not need to complete the remainder of Section 2.4.

Applicant's (SL/DBA) Name

Number/Street		Building, Suite	
City	State	Zip	–
ATTN/Title		E-mail	
Tel. #	– –	Fax #	– –

2.5 OTHER SERVICE LOCATION (SL) INFORMATION/"DOING BUSINESS AS" (DBA) NAME

NUMBER ☐ OF ☐

PLEASE MAKE A COPY OF SECTION 2.5 IF YOU NEED TO LIST MORE THAN FIVE SERVICE LOCATIONS.

Note: Failure to list on the application all locations where services will be provided is a violation of MassHealth regulations 130 CMR 450.222 and 450.223. Please attach each completed copy of Section 2.5 to the signed application. Each such copy will become part of the application.

Number/Street	Building, Suite, or P.O. Box if applicable
City	State / Zip –
ATTN/Title	E-mail
Tel. # – –	Fax # – –
Primary Taxonomy Code	

Number/Street	Building, Suite, or P.O. Box if applicable
City	State / Zip –
ATTN/Title	E-mail
Tel. # – –	Fax # – –
Primary Taxonomy Code	

Number/Street	Building, Suite, or P.O. Box if applicable
City	State / Zip –
ATTN/Title	E-mail
Tel. # – –	Fax # – –
Primary Taxonomy Code	

Number/Street	Building, Suite, or P.O. Box if applicable
City	State / Zip –
ATTN/Title	E-mail
Tel. # – –	Fax # – –
Primary Taxonomy Code	

Number/Street	Building, Suite, or P.O. Box if applicable
City	State / Zip –
ATTN/Title	E-mail
Tel. # – –	Fax # – –
Primary Taxonomy Code	

SECTION 3: GROUP AFFILIATION

NUMBER ☐ OF ☐

This section applies ONLY to applicants seeking to participate with a group practice organization currently enrolled with MassHealth or a group practice organization that is concurrently applying to enroll with MassHealth. Note: Applicants enrolling ONLY with a group practice organization do not need to submit a W-9, EFT, or ERA, as the group practice organization will be paid for services performed by the individual medical practitioner.

PLEASE MAKE A COPY OF SECTION 3 IF YOU NEED TO LIST MORE THAN FOUR GROUP AFFILIATIONS.

Please attach each completed copy of Section 3 to the signed application. Each such copy will become part of the application.

3.1 GROUP AFFILIATION

List the name(s) of each MassHealth-participating group practice organization, the NPI, and the MassHealth Provider ID and the Service Location (PID/SL). The first group practice organization listed will serve as the Primary Service Location.

Group Practice Organization Name			
Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐			
Group Practice Organization NPI		MassHealth PID/SL	
Group Practice Organization Address (number/street)			
City	State	Zip	–

Group Practice Organization Name			
Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐			
Group Practice Organization NPI		MassHealth PID/SL	
Group Practice Organization Address (number/street)			
City	State	Zip	–

Group Practice Organization Name			
Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐			
Group Practice Organization NPI		MassHealth PID/SL	
Group Practice Organization Address (number/street)			
City	State	Zip	–

Group Practice Organization Name			
Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐			
Group Practice Organization NPI		MassHealth PID/SL	
Group Practice Organization Address (number/street)			
City	State	Zip	–

SECTION 4: APPLICANT DISCLOSURES

4.1 CRIMINAL CONVICTION(S) INFORMATION

Has the applicant ever been convicted of any state or federal crime in Massachusetts or any other state in the U.S., including but not limited to any criminal offense relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act (i.e., Medicare, Medicaid, or CHIP)? ☐ Yes ☐ No

If "Yes," provide the following information for each such conviction. Note: Convictions for criminal offenses other than offenses relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act may be omitted if such conviction(s) 1) occurred more than 10 years before the date of this application, or 2) were punishable by imprisonment of less than one year, regardless of the date of such conviction.

Name of the Offense		
Date of Conviction	Court/State	Case or Record Number
Name of the Offense		
Date of Conviction	Court/State	Case or Record Number
Name of the Offense		
Date of Conviction	Court/State	Case or Record Number

4.2 SANCTION(S) INFORMATION

Has the applicant ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without consent by any state (including Massachusetts) or federal agency, board, or other regulatory/licensing agency including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, remedial training, or other educational or public service activities? ☐ Yes ☐ No

If "Yes," for each such action provide the following information.

Agency or Board	Action Taken	Date of Action
Agency or Board	Action Taken	Date of Action
Agency or Board	Action Taken	Date of Action

4.3 PENDING PROCEEDINGS

Is the applicant subject to any proceeding(s) currently pending that could result in a conviction, sanction, or other action reportable in Sections 4.1 or 4.2? ☐ Yes ☐ No

If yes, provide the following information for each such proceeding.

Court/State, Agency, or Board	
Charge or Allegation	Case or Record Number
Court/State, Agency, or Board	
Charge or Allegation	Case or Record Number
Court/State, Agency, or Board	
Charge or Allegation	Case or Record Number

4.4 ADDITIONAL EXPLANATION

The applicant may use the space below to provide additional information regarding the applicant's answers in Sections 4.1, 4.2 or 4.3.
Attach additional pages if necessary.

SECTION 5: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

I certify that I am a medical practitioner applying to enroll as a participating provider in MassHealth.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments are true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein, and that the failure to provide true, accurate, and complete information in this provider application may result in the denial of my enrollment as a participating provider in MassHealth or the termination of any provider agreement resulting from or related to this provider application. I understand that I must notify the MassHealth Provider Enrollment unit of any change in any of the information submitted in this Provider Application, and its attachments in accordance with and within the time specified in 130 CMR 450.223(B).

I hereby authorize MassHealth and its designees to access, and I agree to furnish to MassHealth upon request, any information MassHealth deems relevant to my eligibility and qualifications to be a participating provider in MassHealth, including otherwise privileged or confidential information. I understand and agree that I have the burden to produce adequate information to MassHealth to permit evaluation of my eligibility and qualifications to be a participating provider in MassHealth, and for resolving any doubts that MassHealth may have about my eligibility and qualifications. I understand that I am obligated to cooperate with MassHealth during this application process, any revalidation of enrollment (including, but not limited to, revalidation required by Section 6401 of the Affordable Care Act and occurring at least every five years), or other review process.

Printed Legal Name of Applicant

Signature

Date

Note: Signature stamps, date stamps, or the signature of anyone other than the applicant, are not acceptable.

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Return your completed application packet to the following address.

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021-9162

If you need assistance about the completion of the provider enrollment application or if you have questions about the enrollment process, please e-mail the MassHealth Customer Service Center at providersupport@mahealth.net or call 1-800-841-2900.