# Ancillary Network Contracting and Credentialing Information Form

Point32Health

Harvard Pilgrim Health Care | TUFTS Health Plan

*This application is specific to non-behavioral health providers. For BH please reference this form.*

*Harvard Pilgrim Health Care/Tufts Health Plan requires information about your facility/organization in order to fully evaluate your application to become a participating provider and join our network.*

## Accreditation and Certification Information

**Note:** Please include accreditation certificate information and license (**when applicable**). To access submission information required for **all specialties** refer to the Harvard Pilgrim Health Care Required Credentialing Documentation or Tufts Health Plan Required Credentialing Documentation.

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

### Harvard Pilgrim Health Care

Please submit to our Provider Processing Center at ppc@point32health.org or fax to 866-884-3843.

☐ Harvard Pilgrim Health Care Commercial products

### Tufts Health Plan

For providers in states other than Rhode Island, please email to AncillaryNetworkContracting@point32health.org or fax to 617-673-0909. For Rhode Island providers, please email to RIProviderEnrollment@point32health.org.

☐ Tufts Health Plan Commercial

☐ Tufts Health Public Plans: ☐ Tufts Health Direct ☐ Tufts Health RITogether ☐ Tufts Health Together ☐ Tufts Health One Care

☐ Tufts Medicare Preferred HMO/PPO ☐ Tufts Health Plan Senior Care Option (SCO)

## Facility/Organization Specialty (*please check all that apply*)

- Acute Rehabilitation Facility*
  - LTAC (Long term Acute Care)
  - IRF (Inpatient Rehabilitation Facility)
- Ambulance Service
- Ambulatory Surgical Center*
- Assisted Reproductive Therapy (ART)/IVF*
- Audiology Group+
- Cardiac Rehabilitation Services
- Chiropractic Group+
- Dialysis*
- DME
  - Customized Equipment
  - Manufacturer of Medical Supplies
  - Medical Supplies
  - Oxygen and Respiratory Equipment
  - Orthotic/Prosthetic Supplies
  - Wig
- Early Intervention
- Home Care*
- Home Infusion*
- Hospice*
- Laboratory/Genetics*
- Occupational Therapy Group*
- Physical Therapy Group*
- Radiology/Diagnostic Imaging Facility*
  - CT
  - MRI
  - PET
  - Ultrasound
- Registered Dietician Group+
- Skilled Nursing Facility*
- Sleep Laboratory*
- Speech Therapy Group*
- Urgent Care*
- Other (*specify*):

**require credentialing*

+*Please note, individual practitioners must complete an HCAS form and submit a credentialing application at proview.caqh.org.*

## Facility/Organization Information

### Physical Location (*address where services are rendered, if applicable*)

*If you have additional physical locations, please attach a separate list including address, phone, contact name, TIN, NPI and Medicare Certification Number for each location.*

Facility name

Street Suite

City, State, ZIP

Phone (*this will be used in the Provider Directory*) Fax

Email Website

Contact (*name, title and email address*)

Service hours: Mon Tue Wed Thu Fri Sat Sun

Handicap access? Yes No

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

- Staff receives ADA-compliance training
- Facility can accommodate people who are physically disabled (e.g., accessible parking, wheelchair access to building)
- Facility allows wheelchair access to exam rooms
- Facility can accommodate people who are intellectually/cognitively disabled (e.g., on-site staff to explain instructions)
- Facility can accommodate people who are blind or visually impaired (e.g., service animals allowed, Braille directions available)
- Facility can accommodate people who are deaf or hard of hearing (e.g., American Sign Language or written instruction available)
- Facility is accessible by public transportation (e.g., bus, subway or commuter rail)

Are translation services available? Yes No

Languages other than English at this location

Tax ID # Medicare # (*used to bill Medicare claims*)

NPI # Do you submit claims via: UB-04/837I CMS-1500/837P

Does your facility bill under any other Tax ID or NPI numbers Yes No
(*if yes, please attach a separate list of numbers, payment names and addresses*)

**Facility-specific Information** (*Provide all information that applies to your facility, if applicable.*)

Facility Medicaid certification # Facility Medicare certification #

Number of Medicaid beds: (*if applicable*) Skilled Nursing Facility Acute Rehabilitation Facility

**Legal Notice Address** (*Who is responsible for legal notices?*)

Legal business name

Title of person who notices should be addressed to

Street Suite

City, State, ZIP

Phone Email

Contact *(name, title and email address)*

## Signatory Authority

To allow us to draft the agreement with the current information, please provide the name and title of the person authorized to execute (sign) the Harvard Pilgrim/Tufts Health Plan agreement.

Please print the name of the person authorized to sign the Agreement

Please print the title of the person authorized to sign the Agreement

## Payment/Remittance Address

Payment name (*name should appear exactly as on 1099 forms and claim forms*)

'Remit to' street Suite

City, State, ZIP

Phone Fax

**Acute Rehabilitation Facility**
Please provide name of ambulance provider used for non-emergent transports

**Ambulance**
Types of Transport Service: Wheelchair Emergent Non-emergent

Service area

**Ambulatory Surgical Center**
Please indicate what type of procedures are performed at your ASC (e.g., orthopedic, endoscopy, colonoscopy, eye, etc.)

Please attach a list of the physicians/clinicians who provide anesthesia, laboratory, pathology, and/or radiology services referred to or provided in conjunction with your operation (please provide name, address, TIN, NPI, and phone number). These physicians/clinicians must participate in the Harvard Pilgrim/Tufts Health Plan network.

**Long-term services and supports (LTSS)** *Complete all information that applies to your facility, if applicable.*

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)

**Skilled Nursing Facility**
Please provide name of ambulance provider used for non-emergent transports

## Credentialing (*Who is responsible for credentialing questions and future recredentialing outreach?*)

Name Title

Mailing address:

Street Suite

City, State, ZIP

Phone Fax Email

## Statement of Understanding

I hereby certify that the information given in the enclosed document is accurate. I shall immediately forward to Harvard Pilgrim Health Care/Tufts Health Plan written notification of any modifications, corrections or changes to such information.

The facility agrees to provide ongoing recredentialing data as requested by Harvard Pilgrim Health Care/Tufts Health Plan.

Signature

Print name and title

Facility name

Date

## Required Credentialing Documentation

**To ensure your application is processed in a timely fashion, please submit the required applicable documents as outlined below. Please note this does not include Behavioral Health.**

Please attach the following **required** documents:

### 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, DMEPOS, 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

If your facility is NOT accredited:

- Provide the most recent Department of Health (DPH/CMS) survey report, (must be within 3 years, if applicable to your survey status)
- Follow-up letter of acceptance from the DPH (for corrective action plans) or in lieu of the survey report, a letter from the DPH or applicable state agency which shows that the facility was reviewed and indicates that all deficiencies have been corrected and it passed inspection
- Complaint surveys

### Licensure/Other

- If your facility is required by the state in which you provide services to be licensed, please submit a copy of the most current state license (if license is not current, provide a letter from the DPH indicating the facility's licensure status).
- If you are not required by the state to be licensed please indicate on your application.

| Providers | Required Documentation |
|---|---|
| All | Completed & Signed W-9 |
| Clinics & Free Standing Urgent Care/ Walk-in Centers | Provide us with your Medicare PTAN#. |
| Radiology | Provide a copy of the state issued Radiation Control Program Certificate or Clinic license. |
| Laboratory | Provide a copy of state license and copy of CLIA certificate. |
| Skilled Nursing and Acute Rehabilitation Facilities | Provide a copy of the current state license, accreditation, or Department of Public Health Survey results including the Plan of Correction acceptance letter if applicable. |

For more information, access the Harvard Pilgrim Health Care Required Credentialing Documentation or Tufts Health Plan Required Credentialing Documentation.

*This document is confidential and must not be disclosed to any third party without prior written consent of Harvard Pilgrim Health Care/Tufts Health Plan.*