TUFTS Health Plan

Provider Information Form: Medical Providers/Community Based Organizations

Today's date: ____/_____/_____ Contact name: _____

Phone: _____._____._____ Email: _____

Complete all sections and email the completed form for Tufts Health Public Plans to provider_data_request@tufts-health.com. For Commercial products and Senior Products, email the completed form to provider_information_dept@tufts-health.com.

TYPE OF INFORMATION BEING PROVIDED TO TUFTS HEALTH PLAN

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

☐ New hospital or facility ☐ Current hospital or facility

Tufts Health Public Plans provider ID # or billing ID #: _____Tax ID #: _____

TYPE OF INFORMATION BEING CHANGED/ADDED

☐ New provider profile

☐ New provider profile for existing group

☐ Change panel status

☐ Change existing name

☐ Change existing practice address

☐ Change existing billing address

☐ Change group affiliation

☐ Add information to existing profile

☐ Add practice address

☐ Add billing address (attach W-9)

☐ Add group affiliation

Effective date for change/addition: ____/_____/_____

☐ Terminate provider profile Provider termination effective date: ____/_____/_____

Reason for termination:

☐ Left group practice ☐ PCP changed to specialist ☐ Changed tax ID#

☐ Moved out of state ☐ Practice closed ☐ Deceased

☐ Retired

☐ 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)? Y ☐ N ☐

Medicaid ID # (if applicable): _____ IPA/PHO affiliations: _____

Email: _____

Primary specialty: _____ Board-certified ☐ Board-eligible ☐

Secondary specialty: _____ Board-certified ☐ Board-eligible ☐

Certified Suboxone prescriber provider? Y ☐ N ☐ If yes, certification #: _____

Race
Check all that apply.

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other race
- ☐ I don't know
- ☐ Choose not to answer

Ethnicity
Check all that apply.

- ☐ African
- ☐ African-American
- ☐ American
- ☐ Asian
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander
- ☐ Central American (not otherwise specified)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican/Mexican-American
- ☐ Middle Eastern
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South American (not otherwise specified)
- ☐ Vietnamese
- ☐ Other ethnicity.

  Specify: _____
- ☐ Don't know
- ☐ Choose not to answer

Is the provider Hispanic, Latino, or Spanish? Y ☐ N ☐ Choose not to answer ☐

Special populations served
Check all that apply.

Patients diagnosed with:

- ☐ Chronic illness
- ☐ Co-occurring disorder
- ☐ Dual diagnosis (mental health and substance abuse)
- ☐ Eating disorders
- ☐ Firesetting
- ☐ HIV/AIDS
- ☐ Phobic disorders
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Serious and persistent mental illness
- ☐ Sexual abuse
- ☐ Trauma
- ☐ Other. Specify: _____

Patients who are:

- ☐ Blind or visually impaired
- ☐ Children and adolescents
- ☐ Children in the custody of the DCF
- ☐ Deaf or hard of hearing
- ☐ Homeless
- ☐ People with disabilities
- ☐ Pregnant
- ☐ Sexual offenders

Patients receiving the following services:

- ☐ Cognitive behavioral therapy (CBT)
- ☐ Inpatient electroconvulsive therapy (ECT) services

SECTION B: PRACTICE INFORMATION

Practice location (location 1)

Complete the following for the practice location of the provider in Section A.

Practice name: _____

Address: _____ Phone: _____._____._____

City: _____ State: _____ ZIP: _____

Country: _____ Fax: _____._____._____

Practice email: _____ Practice Contact name: _____

Group affiliation (if applicable): _____ Practice NPI #: _____

Office hours: Sun: _____ Mon: _____ Tue: _____ Wed: _____

Thu: _____ Fri: _____ Sat: _____ Operational 24/7? Y ☐ N ☐

Extended hour available? Y ☐ N ☐ Home visits available? Y ☐ N ☐

Age groups seen: 0-18 ☐ 19-64 ☐ 65+ ☐ Home visits available? Y ☐ N ☐

Is the provider a practicing PCP at this location? Y ☐ N ☐ Accepting new patients? Y ☐ N ☐

Telehealth visits available? Y ☐ N ☐

Practice location (location 2)

Complete the following for the practice location of the provider in Section A.

Practice name: _____

Address: _____ Phone: _____._____._____

City: _____ State: _____ ZIP: _____

Country: _____ Fax: _____._____._____

Practice email: _____ Practice Contact name: _____

Group affiliation (if applicable): _____ Practice NPI #: _____

Office hours: Sun: _____ Mon: _____ Tue: _____ Wed: _____

Thu: _____ Fri: _____ Sat: _____ Operational 24/7? Y ☐ N ☐

Extended hour available? Y ☐ N ☐ Home visits available? Y ☐ N ☐

Age groups seen: 0-18 ☐ 19-64 ☐ 65+ ☐ Home visits available? Y ☐ N ☐

Is the provider a practicing PCP at this location? Y ☐ N ☐ Accepting new patients? Y ☐ N ☐

Telehealth visits available? Y ☐ N ☐

Long-term services and supports (LTSS)

Complete all information that applies to your practice.

Does your organization offer LTSS coordination? Y ☐ N ☐

If yes, the number of long-term support coordinators available?_____

LTSS organization type?

☐ Aging services access point (ASAP) ☐ Recover learning community (RLC)

☐ Independent living center (ILC)

TUFTS Health Plan

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

Facility Medicaid certification#: _____ Facility Medicare certification #:_____

Number of Medicaid beds?

☐ Critical care/Intensive care unit _____ ☐ Inpatient behavioral health _____

☐ Acute care hospital _____ ☐ Skilled nursing facility _____

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

Last name: _____ First name: _____ M.I.: _____

Suffix (e.g., MD, DO, PA, NP): _____ Sex: M ☐ F ☐

Address: _____ Phone: _____._____._____

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? Y ☐ N ☐

SECTION D: PROVIDER FLUENCY

Indicate all languages in which providers and staff are fluent.

Language	Providers	Staff	Language	Providers	Staff
Albanian	☐	☐	Cape Verdean Creole	☐	☐
American Sign Language	☐	☐	Chinese (Cantonese)	☐	☐
Amharic (Ethiopian)	☐	☐	Chinese (Mandarin)	☐	☐
Arabic	☐	☐	Czech	☐	☐
Armenian	☐	☐	Dutch	☐	☐
Bengali	☐	☐			

Language	Providers	Staff	Language	Providers	Staff
English	☐	☐	Romanian	☐	☐
French	☐	☐	Russian	☐	☐
French Creole	☐	☐	Serbian	☐	☐
German	☐	☐	Serbo-Croatian/Croatian	☐	☐
Greek	☐	☐	Somali	☐	☐
Gujarati	☐	☐	Spanish	☐	☐
Haitian Creole	☐	☐	Swahili	☐	☐
Hebrew	☐	☐	Swedish	☐	☐
Hindi	☐	☐	Tagalog (Filipino)	☐	☐
Hungarian (Magyar)	☐	☐	Tamil	☐	☐
Italian	☐	☐	Telugu	☐	☐
Japanese	☐	☐	Thai	☐	☐
Kannada	☐	☐	Turkish	☐	☐
Khmer	☐	☐	Ukrainian	☐	☐
Korean	☐	☐	Urdu	☐	☐
Lao	☐	☐	Vietnamese	☐	☐
Nepali	☐	☐	Yiddish	☐	☐
Persian	☐	☐	Zulu	☐	☐
Polish	☐	☐	Other language	☐	☐
Portuguese	☐	☐	Specify:	_____	
Portuguese Creole	☐	☐	Don't know	☐	☐
Punjabi	☐	☐			

Do you offer interpreter services (e.g., language line, on-site interpreters)? Y ☐ N ☐

SECTION E: 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 ☐ CMS-1500 ☐ 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)? Y ☐ N ☐

If not, are you interested in receiving EFT payments? Y ☐ N ☐

SECTION F: IRS – 1099 ADDRESS

Submit a W-9. **Note:** Legal name must match IRS records.

1099 legal name: _____

1099 legal address: _____

SECTION G: 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*): _____