TUFTS Health Plan

Provider Information Form: Medical Providers/Community Based Organization

Complete all sections and email the completed form for Tufts Health Public Plans products to provider_data_request@point32health.org. For Commercial products and Senior Products, email the completed form to provider_information_dept@point32health.org. For Rhode Island Commercial providers, please use the dedicated email box for these items: RIProviderEnrollment@point32health.org.

Today's date: _____ Contact name: _____

Phone: _____ Email: _____

Type of Information

Check all that apply:

☐ Commercial products

☐ Tufts Health Public Plans products

☐ Senior Products (Tufts Medicare Preferred, 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

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

Tax ID #: _____

Type of Information Being Changed/Added

Check all that apply:

☐ New provider profile ☐ Change existing practice address ☐ Add information to existing profile

☐ New provider profile for existing group ☐ Change existing billing address ☐ Add practice 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 ☐ PCP changed to specialist ☐ Changed tax ID #

☐ Moved out of state ☐ Practice closed ☐ Deceased

☐ Retired ☐ Other: _____

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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: _____

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

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

Certified Suboxone prescriber provider? ☐ Yes; Certification #: _____ ☐ No

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
☐ Chose 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? ☐ Yes ☐ No ☐ Choose not to answer

Special populations served *(Check all that apply)***:**

☐ Chronic illness
☐ Co-occurring disorder
☐ Dual diagnosis (mental health and substance abuse)
☐ Firesetting
☐ HIV/AIDS
☐ Phobic disorders
☐ Serious and persistent mental illness
☐ Sexual abuse
☐ Trauma

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☐ Eating disorders ☐ Post-traumatic stress disorder (PTSD) ☐ Other: Specify: _____

Patients who are:

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

Patients receiving the following services:

☐ Cognitive Behavioral Therapy ☐ 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:_____

Practice address: _____

City/State/ZIP: _____

Country: _____ Secure fax: _____

Practice email: _____ Practice contact name: _____

Practice website: _____

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 Accepting new patients? ☐ 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: _____

Practice email: _____ Practice contact name: _____

Practice website: _____

Group Affiliation (if applicable): _____ Practice NPI: _____

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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 Accepting new patients? ☐ 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 #: _____ Facility Medicare certification #: _____

Number of Medicaid beds?

☐ 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

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)

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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: Provider Fluency

Indicate all languages for which providers and staff are fluent.

Language	Providers	Staff	Language	Providers	Staff
Albanian	☐	☐	Italian	☐	☐
American Sign Language	☐	☐	Japanese	☐	☐
Amharic (Ethiopian)	☐	☐	Kannada	☐	☐
Arabic	☐	☐	Khmer	☐	☐
Armenian	☐	☐	Korean	☐	☐
Bengali	☐	☐	Lao	☐	☐
Cape Verdean Creole	☐	☐	Nepali	☐	☐
Chinese (Cantonese)	☐	☐	Persian	☐	☐
Chinese (Mandarin)	☐	☐	Polish	☐	☐
Czech	☐	☐	Portuguese	☐	☐
Dutch	☐	☐	Portuguese Creole	☐	☐
English	☐	☐	Punjabi	☐	☐
French	☐	☐	Romanian	☐	☐
French Creole	☐	☐	Russian	☐	☐
German	☐	☐	Serbian	☐	☐
Greek	☐	☐	Serbo-Croatian/Croatian	☐	☐
Gujarati	☐	☐	Somali	☐	☐
Haitian Creole	☐	☐	Spanish	☐	☐
Hebrew	☐	☐	Swahili	☐	☐
Hindi	☐	☐	Swedish	☐	☐
Hungarian (Magyar)	☐	☐	Tagalog (Filipino)	☐	☐

Language	Providers	Staff	Language	Providers	Staff
Tamil	☐	☐	Vietnamese	☐	☐
Telugu	☐	☐	Yiddish	☐	☐
Thai	☐	☐	Zulu	☐	☐
Turkish	☐	☐	Don't know	☐	☐
Ukrainian	☐	☐	Other language	☐	☐
Urdu	☐	☐			

Specify: _____

Do you offer interpreter services (e.g. language line, on-site interpreters? ☐ Yes ☐ No

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 ☐ CMS1500 ☐ Both

Name on check: _____ *Check one:* ☐ Individual name ☐ Group name

Address: _____

City/State/ZIP: _____

☐ Send 1099 to this address
☐ Send payments to this address
☐ This is an EDI 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 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)*: _____