TUFTS Health Plan

ANCILLARY PRACTITIONER DATA FORM
NUTRITIONAL COUNSELING

Please email to AlliedContracting@tufts-health.com or fax to **617.673.0909.**
Please note: A credentialing application must also be submitted at proview.caqh.org.

GENERAL INFORMATION – MISSING INFORMATION WILL DELAY YOUR APPLICATION

Name _____
Last First Middle Degree/Specialty

Individual NPI _____ Date of birth____/____/_____ SS# _____-_____-_____

Provider's email _____

DBA, Group or Practice Name (if applicable) _____

Are we adding you to a group practice? YES ☐ NO ☐ Are you a Medicare participating provider? YES ☐ NO ☐

CAQH Information Is your CAQH application updated and reattested to within the last 3 months? YES ☐ NO ☐
Did you include 5-year work history in CAQH in month/year format? YES ☐ NO ☐
CAQH ID# _____ Have you granted Tufts Health Plan access to your CAQH account? YES ☐ NO ☐

Payment Information Payee NPI _____ Tax ID# _____-_____

To whom should checks be made payable? _____

Payment Address (should match W-9 & CAQH) Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Practice Address (general liability insurance must be attached for all practice locations)

Street _____ Phone _____

City, State ZIP _____ Fax _____

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

For additional addresses check here ☐ and attach a separate sheet. Please include all practice addresses for directories and update all addresses with www.proview.caqh.org

Please provide the contact information for the person we should contact if we have any questions about your application:

Name _____ Phone _____ Fax _____

Email _____

CREDENTIALS – Check all that apply

☐ CDE (Certified Diabetic Educator) ☐ MS ☐ RD ☐ LDN ☐ Other:_____

REQUIRED CREDENTIALING/CONTRACTING DOCUMENTS – Please attach

- ☐ Documentation of current professional liability insurance ($1 million per incident/$3 million aggregate). Must show the individual provider's name on the certificate, roster or a letter from the insurance company unless the professional liability information in CAQH is current and attested to. ***(required)***
- ☐ Completed Past 5 Years' Work History Form ***(required)***
- ☐ Form W-9 for payments (payment address should match CAQH and above) ***(required)***
- ☐ Documentation of your (or your landlord's) current general liability "premises" insurance ($1 million per incident/$1 million aggregate). Must show addresses for any/all practice sites. This coverage should include, but not be limited to, claims for bodily injury, property damage and legal liability on the insured's premises. ***(required)***
- ☐ Copy of graduate school diploma ***(required)***
- ☐ Brief statement defining your scope of service (specialties) ***(required)***
- ☐ Copy of CDE certificate ***(if applicable)***

Internal Use:

PROV ID _____ GROUP/PAYEE _____ SPEC 9900

PCAT 01 05, TOP 59, PRAC 01 02 05 REST EX 77

(Revised 05/16, #5166775) PI Initials _____ Date_____ PO Initials _____ Date _____