TUFTS Health Plan

Payment Attestation for Primary Care Physicians and PCP/Specialists

Complete this form if the provider will be a PCP with a member panel.

This form should be completed by the physician group (IPA or PHO). Please indicate who should receive **PCP Management** payments and to what address the payments should be sent.

PHYSICIAN

Complete this form if the provider will be a PCP with member panel

Last name: _____ First name: _____ NPI: _____

Name of physician, group, IPA/PHO, or IDN that checks should be made payable to:

_____

Tax identification number of above entity: _____

Tufts Health Plan legacy number or NPI number of **payment** entity: _____

Mailing address for checks:

Address 1: _____ Address 2: _____

City: _____ State: _____ ZIP: _____

The following should be completed by the IPA/PHO or billing company, if applicable.

IPA/PHO

IPA/PHO name: _____ IPA number: _____

Approved by: _____

Print name: _____ Title: _____

BILLING COMPANY

Company name: _____

Approved by: _____

Print name: _____ Title: _____

Please return with your applications to:
Tufts Health Plan, 705 Mount Auburn Street MS-81, Watertown, MA 02472