TUFTS Health Plan

REQUEST ADDITION OF PROVIDER TO GROUP PT/OT/ST

Please email to AncillaryNetworkContracting@point32health.org or fax to **617.673.0909**

REQUEST ADDITION OF PT/OT/ST PROVIDER TO GROUP

GROUP INFORMATION

Type of practice (check all that apply): ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Other: _____

Group/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

Group NPI _____

Group Tax ID _____

Group Contact Name and Title: _____

Contact Telephone Number: _____

Contact E-mail Address: _____

Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

Mailing Address

Street _____ City, State ZIP _____

Mailing Address Phone _____ Fax _____

NEW PROVIDER(S) INFORMATION

List of therapists to be authorized to practice under the group's contract (check here ☐ and attach a separate sheet if necessary):

Name & Degree _____

NPI _____ Effective Date _____ DOB _____ SSI _____

Name & Degree _____

NPI _____ Effective Date _____ DOB _____ SSI _____

Name & Degree _____

NPI _____ Effective Date _____ DOB _____ SSI _____

Name & Degree _____

NPI _____ Effective Date _____ DOB _____ SSI _____

CERTIFICATION, AUTHORIZATION AND RELEASE

Group/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

By submission of this form, the undersigned hereby certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief.

_____ _____

Authorized Representative's Signature Date

_____

Authorized Representative's Name (Please Print)

_____

Authorized Representative's Title