TUFTS Health Plan

ANCILLARY PRACTITIONER DATA FORM
BEHAVIORAL HEALTH/
SUBSTANCE USE DISORDER/METHADONE CLINIC

Please use this checklist as a guide when completing the requirements to become a participating provider with Tufts Health Plan. For questions, please contact the Tufts Health Plan Credentialing Department at 617.972.9495. Please email completed application to: tufts_health_plan_credentialing_department@tufts-health.com or fax to 617.972.9591. To facilitate review of your application, please return all materials together.

Provider Eligibility Criteria
Organizations licensed by the state as Behavioral Health Clinics are eligible to apply for consideration as contracting providers in the Tufts Health Plan outpatient behavioral health network.

Application Checklist

- ☐ A completed Ancillary Provider Application
- ☐ A completed and signed W-9 Form
- ☐ Copy of the State site visit within the last three years

Insurance

- ☐ The clinic must maintain professional liability insurance coverage in the amount of $1 million per incident, and $3 million in the aggregate per year covering all clinicians included in the agreement.

Articles of Incorporation

- ☐ A copy of the Clinic's Articles of Incorporation or similar documents submitted to the state or local authorities in order to register the group with appropriate governmental units.

Please email to tufts_health_plan_credentialing_department@tufts-health.com or fax to **617.972.9591**.
Please review Behavioral Health/Substance Use Disorder Clinic Application Procedures for a list of required attachments.

GENERAL INFORMATION

Contract/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

Type of Clinic: ☐ Behavioral Health ☐ Substance Use Disorder/Methadone

NPI _____ Is the clinic Medicare participating? YES ☐ NO ☐
If yes, please enclose proof of Medicare participation (e.g., Medicare award letter)

PID/SIL if applicable _____ Is the clinic MassHealth/Medicaid participating? YES ☐ NO ☐

Participating in Rhode Island assistance program? YES ☐ NO ☐

Primary Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

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

Secondary Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

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.

Internal Use:

PROV ID _____
PCAT 01, TOP 24,45,67 PRAC 03 SPEC 9900
(Revised 05/16, #5165054/5183266) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77

TUFTS Health Plan

ANCILLARY PRACTITIONER DATA FORM
BEHAVIORAL HEALTH/
SUBSTANCE USE DISORDER/METHADONE CLINIC

Corporate affiliated providers with different names and locations need to complete separate applications.

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Corporate Affiliation (if different) _____

Street _____ City, State ZIP _____

Managed by _____

Please explain in detail any name changes that have occurred in the past 3 years and attach appropriate documentation:

_____

PRACTICE INFORMATION

President/CEO _____

Office Mgr/Contact Person _____ Phone _____ Fax _____

Email _____

Please provide the contact information for the person we should contact if we have any questions about the information on this form.

PAYMENT INFORMATION

Payee NPI _____ Tax ID# _____-_____

To whom should checks be made payable? _____

Payment Address Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Please enclose a copy of your W-9 form (request for taxpayer ID). Payee name and tax ID# must match information on your W-9.

Race *Please check all that apply.*

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

Special populations served *Please check all that apply.*

Patients diagnosed with:

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

Patients who are:

- ☐ Blind or visually impaired
- ☐ Children or 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

☐ Other Please Specify: _____

Ethnicity *Please 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
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican/ Mexican-American
- ☐ Middle Eastern
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South American (not otherwise specified)
- ☐ Vietnamese

TUFTS Health Plan

ANCILLARY PRACTITIONER DATA FORM
BEHAVIORAL HEALTH/
SUBSTANCE USE DISORDER/METHADONE CLINIC

- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Other ethnicity *Please specify:* _____
- ☐ Don't know
- ☐ Choose not to answer

Is the provider Hispanic, Latino, or Spanish? YES ☐ NO ☐ Choose not to answer ☐

Areas of Focus *Please check all that apply.*

- ☐ Attention-deficit/hyperactivity disorder (ADHD)
- ☐ Anger issues
- ☐ Anxiety
- ☐ Autism spectrum disorders
- ☐ Bipolar disorder
- ☐ Dialectical behavioral therapy (DBT)
- ☐ Depression
- ☐ Gay, lesbian, bisexual, transgender (LGBT) issues
- ☐ Gender identity disorder
- ☐ Geriatric behavioral health
- ☐ Group therapy
- ☐ Marriage and family therapy
- ☐ Medical illness and therapy
- ☐ Medication management and therapy
- ☐ Neuropsychological testing (adolescents)
- ☐ Neuropsychological testing (children)
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Postpartum depression and/or psychosis
- ☐ Play therapy
- ☐ Psychological testing (adolescents)
- ☐ Psychological testing (children)
- ☐ Sleep disorders
- ☐ Substance use

Americans with Disabilities Act compliance *Please 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/visually impaired (e.g. service animals allowed, Braille directions available)
- ☐ Practice can accommodate people who are deaf/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)

REQUIRED CREDENTIALING/CONTRACTING DOCUMENTS – Please attach/complete

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 (enclosed) ***(required)***

Form W-9 for payments (payment address should match CAQH and above) ***(required)***

Copy of board certification (LICSW and prescribing nurses only) ***(if applicable)***
Please note: *this is* ***not*** *your state license nor is it membership alone in an association such as the NASW. Board certification is an additional, voluntary certification process whereby a person is tested and approved to practice in a specialty field after successful completion of the requirements of a board of specialists in that field (for example, The American Nurses Credentialing Center or The National Association of Social Workers).*

Psychiatrist or prescribing nurse to whom you refer for medication management ***(required)***

Provider's name _____

Provider who provides your emergency and vacation coverage ***(required)***

Provider's name _____

CERTIFICATION, AUTHORIZATION AND RELEASE

Contract/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

In submitting this application for credentialing (or recredentialing) by Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., or any Tufts Health Plan affiliate (as defined in your written agreement to provide services to Tufts Health Plan members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. 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. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.

Internal Use:

PROV ID _____
PCAT 01, TOP 24,45,67 PRAC 03 SPEC 9900
(Revised 05/16, #5165054/5183266) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77

3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

_____ _____

Authorized Representative's Signature Date

_____

Authorized Representative's Name (Please Print)

_____

Authorized Representative's Title