Ancillary Data Form Community Mental Health Center/ Substance Use Treatment Center

Point32Health

Harvard Pilgrim Health Care TUFTS Health Plan

Please use this checklist as a guide when completing the requirements to become a participating provider with Harvard Pilgrim Health Care/Tufts Health Plan.

Please select applicable plans for which you would like to be credentialed:

Harvard Pilgrim Health Care

Please return this document, along with the other contracting materials provided, to our Provider Processing Center at ppc@point32health.org or by fax to 866-884-3843.

- ☐ Harvard Pilgrim Health Care Commercial products

Tufts Health Plan

Please email the completed application to Tufts_Health_Plan_Credentialing_Department@point32health.org or fax to 617-972-9591. For Rhode Island providers, please email to RIProviderEnrollment@point32health.org. To facilitate review of your application, please return all materials together.

- ☐ Tufts Health Plan Commercial products
- ☐ Tufts Health Public Plans Massachusetts products
- ☐ Tufts Health RITogether
- ☐ Senior Products (Tufts Medicare Preferred, Tufts Health Plan Senior Care Options [SCO])

Please review the Credentialing Process for Nonphysician Outpatient Behavioral Health/LADC1/Methadone Clinical Providers for additional information regarding credentialing and contracting with us. For questions, please contact the Tufts Health Plan Credentialing Department at 617-972-9495.

Provider Eligibility Criteria

Organizations licensed by the state as Behavioral Health Clinics are eligible to apply for consideration as contracted behavioral health care providers for Harvard Pilgrim Health Care/Tufts Health Plan.

Application Checklist

- ☐ A completed Ancillary Data Form Community Mental Health Center/Substance Use Treatment Center Application
- ☐ A completed and signed W-9 Form
- ☐ A Federally Required Disclosures Form (*applicable to MA & RI only*)
- ☐ Copy of the State site visit within the last three years
- ☐ Copy of State License

Insurance

- ☐ The clinic must maintain professional liability insurance 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.

General Information *Missing information will delay your application*

Contract/Legal Entity Name

DBA/Practice Name (*if applicable*)

NPI

Type of Clinic: ☐ Community Mental Health Center ☐ Substance Use Treatment Center

Participating in Medicare? ☐ YES ; Medicare ID ☐ NO

Participating in MassHealth/Medicaid? ☐ YES ; MassHealth ID ☐ NO

Participating in Rhode Island Medical Assistance Program (Medicaid)? ☐ YES ; ID ☐ NO

Primary Practice address Phone

Street 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 Phone

Street 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

Check here for additional addresses and attach a separate sheet.

Mailing Information

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

Mailing address Phone

Street City, State ZIP Fax

Corporate Affiliation (*if different*) Phone

Street City, State ZIP Fax

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

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

Phone Fax Email

Payment Information

Payee NPI Tax ID# -

To whom should checks be made payable?

Payment address Phone

Street City, State ZIP Fax

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.

Special populations served *Check all that apply*

Patients who are:

- Adolescents
- Adults
- Child welfare
- Children
- Children or child in care of or custody of DCF (Department of Children and Families)
- Geriatrics
- Homelessness
- Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
- Military and veterans
- Youth affiliated with DYS (Department of Youth Services) either detained or committed

Attributes and Modalities of Care *Check all that apply*

Treatment options:

- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Group Therapy
- Marriage and Family Therapy
- Medical Illness Therapy
- Medication Management and Therapy
- Neuropsychological Testing (Adults)
- Neuropsychological Testing (Adolescents)
- Neuropsychological Testing (Children)
- Play Therapy
- Postpartum Depression and/or Psychosis
- Prolonged Exposure
- Psychological Testing (Adults)
- Psychological Testing (Adolescents)
- Psychological Testing (Children)
- Transcranial Magnetic Stimulation (TMS)

Physical conditions:

- Blindness or visual impairment
- Deafness or hard of hearing
- People with disabilities
- Physical disabilities

Areas of Expertise *Check all that apply*

- Adoption
- Anger management
- Anxiety
- Attention-deficit/hyperactivity disorder (ADHD)
- Autism spectrum disorders
- Bipolar disorder
- Brain injury
- Chronic illness
- Compulsive gambling
- Co-occurring disorders
- Crisis intervention
- Depression
- Developmental disabilities
- Eating disorders
- Fire setting
- Foster care
- Gender identity disorder
- Geriatric behavioral health
- Grief counseling
- HIV/AIDs
- Infertility
- Learning disabilities
- Methadone maintenance
- Mood disorders
- Obsessive-compulsive disorder (OCD)
- Personality disorders
- Phobic disorders
- Post-traumatic stress disorder (PTSD)
- Race based trauma
- Schizophrenia
- Serious mental illness
- Sexual abuse/rape trauma
- Sexual dysfunction
- Sexual offenders
- Sleep disorders
- Substance use
- Suicide prevention
- Transgender
- Trauma

Levels of Care Provided *Check all that apply*

- Community Behavioral Health Center
- Dual Diagnosis Intensive Outpatient Program
- Dual Diagnosis Partial Hospitalization Program
- Early Intensive Behavioral Intervention (EIBI)
- Eating Disorder Intensive Outpatient Program
- Eating Disorder Partial Hospitalization Program
- Electroconvulsive Therapy (ECT)
- Family Support and Training (FS&T) for Children and Adolescents
- In-Home Behavioral Services for (IHBS) Children and Adolescents
- In-Home Therapy (IHT) for Children and Adolescents
- Intensive Care Coordination (ICC) for Children and Adolescents
- Methadone Treatment
- Medication Assisted Treatment (MAT)
- Outpatient Behavioral Health Program
- Outpatient Detoxification Program
- Psychiatric Intensive Outpatient Program
- Psychiatric Partial Hospitalization Program
- Therapeutic Mentoring for Children and Adolescents
- Substance Use Disorder Intensive Outpatient Program
- Substance Use Disorder Partial Hospitalization Program

Americans with Disabilities Act 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/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)

CERTIFICATION, AUTHORIZATION AND RELEASE

Contract/Legal Entity Name

DBA/Practice Name (*if applicable*)

In submitting this application for credentialing (or recredentialing) by Harvard Pilgrim Health Care (collectively "Plan") / 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.
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