TUFTS Health Plan

Provider Information Form

Behavioral Health Providers/
Community-based Organizations
Email: provider_data_request@tufts-health.com

Today's date /__ /__ Contact name _____ Phone ____ - ____ - ____

Email _____

Please complete ALL sections of this form.

TYPE OF INFORMATION BEING PROVIDED TO TUFTS HEALTH PLAN

☐ New individual provider or provider group ☐ Current individual provider or provider group

☐ New hospital or facility ☐ Current hospital or facility

Tufts Health Public Plans provider ID # or billing ID # _____ Tax ID # _____

TYPE OF INFORMATION BEING CHANGED/ADDED

☐ New provider profile ☐ Change existing name ☐ Add information to existing profile

☐ New provider profile for existing group ☐ Change existing practice address ☐ Add practice address

☐ Change existing billing address ☐ Add billing address (attach W-9)

☐ Change group affiliation ☐ Add group affiliation

Effective date for change/addition ___ /___ /___

☐ Terminate provider profile Provider termination effective date ___ /___ /___

Reason for termination ☐ Left group practice ☐ Moved out of state ☐ Retired ☐ PCP changed to specialist

☐ Practice closed ☐ Changed tax ID # ☐ Deceased ☐ Other _____

SECTION A: PROVIDER INFORMATION

Provider information

Last name _____ First name _____ M.I. _____ Sex ☐ M ☐ F CAQH ID # _____

DOB ___ /___ /___ SSN _____ DEA # _____ MA lic # _____

NPI # (if applicable) _____ Medicare ID # _____

Is the provider contracted with MassHealth (Medicaid)? ☐ Y ☐ N Medicaid ID # (if applicable) _____

IPA/PHO affiliations _____ Email _____

Certified Suboxone prescriber provider? ☐ Y ☐ N If yes, certification # _____

Licensures, degrees and certifications obtained *Please check all that apply.*

☐ APRN	☐ EdD	☐ LMFT	☐ MSW	☐ RN	☐ MD
☐ BS	☐ LADC	☐ LMHC	☐ NP	☐ RNCS	☐ Board-certified
☐ CADAC	☐ LCSW	☐ MA	☐ PhD		☐ Board-eligible
☐ CNS	☐ LICSW	☐ MEd	☐ PsyD		

Race *Please check all that apply.*

☐ American Indian/Alaska Native ☐ White

☐ Asian ☐ Other race

☐ Black/African-American ☐ Don't know

☐ Native Hawaiian or other Pacific Islander ☐ Choose not to answer

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
- ☐ Eastern European
- ☐ European
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican/Mexican-American
- ☐ Middle Eastern
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South American (not otherwise specified)
- ☐ Vietnamese
- ☐ Other ethnicity *Please specify*: _____
- ☐ Don't know
- ☐ Choose not to answer

Is the provider Hispanic, Latino or Spanish? ☐ Y ☐ N ☐ 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 (GLBT) 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

Special populations served *Please check all that apply.*

Patients diagnosed with:

- ☐ Chronic illness
- ☐ Co-occurring disorder
- ☐ Dual diagnosis (mental health and substance abuse)
- ☐ Eating disorders
- ☐ Firesetting
- ☐ HIV/AIDS
- ☐ Phobic disorders
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Serious and persistent mental illness
- ☐ Sexual abuse
- ☐ Trauma
- ☐ Other *Please specify:* _____

Patients who are:

- ☐ Blind or visually impaired
- ☐ Children and 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

SECTION B: PRACTICE INFORMATION

Practice location (location 1) *Please complete the following for the practice location of the provider in Section A.*

Practice name _____

Address _____ Phone - -

City _____ State _____ ZIP _____

County _____ Fax - - Practice email _____

Practice contact name _____

Group affiliation (if applicable) _____ Practice NPI # _____

Office hours Sun _____ Mon _____ Tue _____ Wed _____

Thu _____ Fri _____ Sat _____ Operational 24/7? ☐ Y ☐ N

Extended hours available? ☐ Y ☐ N Home visits available? ☐ Y ☐ N Accepting new patients? ☐ Y ☐ N

Age groups seen ☐ 0 – 18 ☐ 19 – 64 ☐ 65+

Is hospital/facility a licensed facility through the Massachusetts Department of Public Health? ☐ Yes ☐ No

If yes, Licensure # _____ Location _____

Additional practice location (location 2) *Please include only addresses with the same tax ID # as location 1.*

Practice name _____

Address _____ Phone - -

City _____ State _____ ZIP _____

County _____ Fax - - Practice email _____

Practice contact name _____

Group affiliation (if applicable) _____ Practice NPI # _____

Office hours Sun _____ Mon _____ Tue _____ Wed _____

Thu _____ Fri _____ Sat _____ Operational 24/7? ☐ Y ☐ N

Extended hours available? ☐ Y ☐ N Home visits available? ☐ Y ☐ N Accepting new patients? ☐ Y ☐ N

Age groups seen ☐ 0 – 18 ☐ 19 – 64 ☐ 65+

Is hospital/facility a licensed facility through the Massachusetts Department of Public Health? ☐ Yes ☐ No

If yes, Licensure # _____ Location _____

Please separately attach all of the above information along with Section D information for any additional practice locations.

Long-term services and supports (LTSS) *Please complete all information that applies to your practice.*

Does your organization offer LTSS coordination? ☐ Y ☐ N

If yes, number of long-term support coordinators available _____

LTSS organization type?

☐ Aging services access point (ASAP) ☐ Independent living center (ILC)

☐ Recovery learning community (RLC)

Facility-specific information *Please complete all information that applies to your facility.*

Facility Medicaid certification # _____ Facility Medicare certification # _____

Number of Medicaid beds?

☐ Critical care/Intensive care unit _____ ☐ Acute-care hospital _____

☐ Inpatient behavioral health _____ ☐ Skilled nursing facility _____

Is hospital/facility a licensed facility through the Massachusetts Department of Public Health?

☐ Yes *Licensure #* _____ ☐ No

Americans with Disabilities Act (ADA) 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)

SECTION C: PROVIDER FLUENCY

Please indicate all languages for which providers and staff are fluent.

Language	Provider	Staff	Language	Provider	Staff
Albanian	☐	☐	German	☐	☐
American Sign Language	☐	☐	Greek	☐	☐
Amharic (Ethiopian)	☐	☐	Gujarati	☐	☐
Arabic	☐	☐	Haitian Creole	☐	☐
Armenian	☐	☐	Hebrew	☐	☐
Bengali	☐	☐	Hindi	☐	☐
Cape Verdean Creole	☐	☐	Hungarian (Magyar)	☐	☐
Chinese (Cantonese)	☐	☐	Italian	☐	☐
Chinese (Mandarin)	☐	☐	Japanese	☐	☐
Czech	☐	☐	Kannada	☐	☐
Dutch	☐	☐	Khmer	☐	☐
English	☐	☐	Korean	☐	☐
French	☐	☐	Lao	☐	☐
French Creole	☐	☐	Nepali	☐	☐

Language	Provider	Staff	Language	Provider	Staff
Persian	☐	☐	Tagalog (Filipino)	☐	☐
Polish	☐	☐	Tamil	☐	☐
Portuguese	☐	☐	Telugu	☐	☐
Portuguese Creole	☐	☐	Thai	☐	☐
Punjabi	☐	☐	Turkish	☐	☐
Romanian	☐	☐	Ukrainian	☐	☐
Russian	☐	☐	Urdu	☐	☐
Serbian	☐	☐	Vietnamese	☐	☐
Serbo-Croatian/Croatian	☐	☐	Yiddish	☐	☐
Somali	☐	☐	Zulu	☐	☐
Spanish	☐	☐	Other language	☐	☐
Swahili	☒	☐	*Please specify.*		
Swedish	☐	☐	Don't know	☐	☐

Do you offer interpreter services (e.g., language line, on-site interpreters)? ☐ Y ☐ N

SECTION D: BILLING INFORMATION

Please submit a W-9 for each new billing address, if there are additional billing addresses.

Tax ID # _____

For this tax ID #, which claim form(s) will you use? *Please check one:* ☐ UB04 ☐ CMS-1500 ☐ Both

Name on check _____ (*please check one*) ☐ Individual name ☐ Group name

Address _____

City _____ State _____ ZIP _____

☐ Send 1099 to this address. ☐ Send payments to this address. ☐ This is an EDI address. ☐ This is a new billing address.

Do you currently receive payments from us by electronic funds transfer (EFT)? ☐ Y ☐ N

If not, are you interested in receiving EFT payments? ☐ Y ☐ N

SECTION E: IRS – 1099 ADDRESS

Please submit a W-9. NOTE: Legal name must match IRS records.

1099 legal name _____

1099 legal address _____

SECTION F: ATTESTATION

I hereby certify that the above information is accurate and complete. I understand that Tufts Health Public Plans is relying on my certification to make submissions to state and federal regulators and to distribute information to members, and that submission of inaccurate information may result in contract termination and legal action.

Provider signature _____ Date ___ /___ /___

Provider name *Please print.* _____