Provider Information Form: Medical Providers/Community Based Organization

TUFTS Health Plan
a Point32Health company

Complete all sections and email the completed form to Provider_Information_Dept@point32health.org.

Today's date / / Contact name
Phone Email

Type of Information (*check all that apply*)

Tufts Health Plan Commercial products
Tufts Health Public Plans products (Direct, Together, Tufts Health One Care, and RITogether)
Senior Products (Tufts Medicare Preferred, Tufts Health Plan Senior Care Options [SCO])

Check one of the following provider types:

New individual provider or provider group Current individual provider or provider group
New hospital or facility Current hospital or facility
Provider ID # or billing ID # Tax ID #

Type of Information Being Changed/Added (*check all that apply*)

New provider profile New provider profile for existing group Add information to existing profile Add practice address
Change existing practice address Change existing billing address Change panel status Change group affiliation
Add billing address (attach W-9) Change existing name 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 Changed tax ID #
Practice closed Deceased Other

Section A: Provider Information

Last Name First Name M.I.
Suffix (e.g., MD, DO, PA, NP) Sex M F DOB / /
SSN DEA #
MA lic # NPI # (*if applicable*)
Medicare ID # CAQH ID #
Is the provider contracted with MassHealth (Medicaid)? Yes No
Medicaid ID # (*if applicable*) IPA/PHO affiliations
Email Phone
Primary Specialty Board-certified Board-eligible
Secondary Specialty Board-certified Board-eligible
Certified Suboxone prescriber provider? Yes; Certification # No

Race (*check all that apply*)

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

Ethnicity (*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 (*specify*)
Don't know Choose not to answer

Is the provider Hispanic, Latino, or Spanish? Yes No Choose not to answer

Special populations served (*check all that apply*)

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 (*specify*)

Patients who are

Blind or visually impaired Children and adolescents Children in the custody of DCF Deaf or hard of hearing
Homeless People with disabilities Pregnant Sexual offenders

Patients receiving the following services

Cognitive Behavioral Therapy Inpatient electroconvulsive therapy (ECT) services

Section B: Practice Information

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

Practice name
Practice address
City/State/ZIP
Country Secure fax Phone
Practice email Practice website
Practice contact name
Group Affiliation (*if applicable*) Practice NPI #
Office Hours: Sun Mon Tue Wed Thu Fri Sat
Operational 24/7? Yes No Extended hour available? Yes No Home visits available? Yes No
Age groups seen 0-18 19-64 65+ Home visits available? Yes No
Is the provider a practicing PCP at this location? Yes No
Available to see new members Yes No Available to see new members with a waitlist of 4 weeks or less Yes No

Practice location (location 2) *Include only addresses with the same tax ID # as location 1.*

Practice name
Practice address
City/State/ZIP
Country Secure fax Phone
Practice email Practice website
Practice contact name
Group Affiliation (*if applicable*) Practice NPI #
Office Hours: Sun Mon Tue Wed Thu Fri Sat
Operational 24/7? Yes No Extended hour available? Yes No Home visits available? Yes No
Age groups seen 0-18 19-64 65+ Home visits available? Yes No
Is the provider a practicing PCP at this location? Yes No
Available to see new members Yes No Available to see new members with a waitlist of 4 weeks or less Yes No

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

Does your organization offer LTSS coordination?

Yes No If yes, the 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 *Provide all information that applies to your facility.*

Facility Medicaid certification # Number of Medicaid beds?

Facility Medicare certification #

Critical care/Intensive care unit

Inpatient behavioral health

Acute care hospital

Skilled nursing facility

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

Yes; Licensure # No

American with Disabilities Act (ADA) 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 or visually impaired (e.g., service animals allowed, Braille directions available)
Practice can accommodate people who are deaf or 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: Covering Provider Information *Note: Complete if for PCPs only.*

Last Name First Name M.I.

Suffix (e.g., MD, DO, PA, NP) Sex M F

Address

City/State/ZIP

NPI # (*if applicable*) Tax ID #

Separately attach all of the above information for any additional covering providers.

Do providers cover for each other? Yes No

Section D: Provider Fluency *Indicate all languages for which providers and staff are fluent.*

Language	*Provider/Staff*	*Language*	*Provider/Staff*	*Language*	*Provider/Staff*	*Language*	*Provider/Staff*
Albanian		French Creole		Lao		Swahili	
American Sign Language		German		Nepali		Swedish	
Amharic (Ethiopian)		Greek		Persian		Tagalog (Filipino)	
Arabic		Gujarati		Polish		Tamil	
Armenian		Haitian Creole		Portuguese		Telugu	
Bengali		Hebrew		Portuguese Creole		Thai	
Cape Verdean Creole		Hindi		Punjabi		Turkish	
Chinese (Cantonese)		Hungarian (Magyar)		Romanian		Ukrainian	
Chinese (Mandarin)		Italian		Russian		Urdu	
Czech		Japanese		Serbian		Vietnamese	
Dutch		Kannada		Serbo-Croatian/Croatian		Yiddish	
English		Khmer		Somali		Zulu	
French		Korean		Spanish		Don’t know	

Other language (*specify*)

Do you offer interpreter services (e.g. language line, on-site interpreters? Yes No

Section E: Billing Information *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? *Check one*: UB04 CMS1500 Both

Name on check *Check one*: Individual name Group name

Address

City/State/ZIP

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

Do you currently receive payments from us by electronic funds transfer (EFT)? Yes No

If not, are you interested in receiving EFT payments? Yes No

Section F: IRS – 1099 Address *Submit a W-9. Note: Legal name must match IRS records.*

1099 legal name

1099 legal address

City/State/ZIP

Section G: 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*)

CLEAR FORM