Provider Information Form: Behavioral Health 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 HMO, 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
Tufts Health Public Plans 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.
CAQH ID # Sex M F DOB / /
SSN DEA #
MA lic # NPI # (*if applicable*)
Medicare ID #
Is the provider contracted with MassHealth (Medicaid)? Yes No
Medicaid ID # (*if applicable*) IPA/PHO affiliations
Email

Licensures, degrees and certifications obtained:

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

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

Areas of focus (*check all that apply*)

Attention-deficit/hyperactivity disorder (ADHD)
Anger issues
Anxiety
Autism spectrum disorders
Bipolar disorder
Dialectical behavioral therapy (DBT)
Depression
Lesbian, gay, bisexual, transgender (LGBTQ+) 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 (*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

Available to see new members Available to see new members with a waitlist of 4 weeks or less

Close panel to all new members, but keep existing panel Concierge practice (90 day notice required)

Other (*please specify*):

Telehealth visits available? 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

Available to see new members Available to see new members with a waitlist of 4 weeks or less

Close panel to all new members, but keep existing panel Concierge practice (90 day notice required)

Other (*please specify*):

Telehealth visits available? 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: Provider fluency *Indicate all languages for which providers and staff are fluent.*

Other language (*specify*)

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

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	

Section D: 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 E: IRS – 1099 address *Submit a W-9.* ***Note:*** *Legal name must match IRS records.*

1099 legal name

1099 legal address

City/State/ZIP

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*)

CLEAR FORM