

BMC HealthNet Plan Provider Data Form

Please note: An incomplete form may result in delayed credentialing.

Today's Date _____

Provider Demographics		
Provider Name:	<input type="checkbox"/> PCP <input type="checkbox"/> Hospital Based <input type="checkbox"/> Specialist <input type="checkbox"/> Locum Tenen	
Provider Title:	*Please complete Locum Tenen Credentialing Form	
Mailing Contact Name:	Mailing Contact E-mail:	
Mailing Phone Number:		
Primary Hospital Affiliation Name:		
Effective Date of Privileges:	Category of Privileges:	
Community Health Center Name:	<input type="checkbox"/> Community Health Center <input type="checkbox"/> Rural Health Center <input type="checkbox"/> Federally Qualified Health Center	
Collaborating MD (include PAs and NPs):		
Is provider a PCP? Y: <input type="checkbox"/> N: <input type="checkbox"/> Gender served: M: <input type="checkbox"/> F: <input type="checkbox"/> Are there age restrictions? Y: <input type="checkbox"/> N: <input type="checkbox"/> If a PCP, do you participate in: MCO: <input type="checkbox"/> ACO: <input type="checkbox"/> If in an ACO, which ACO: BACO/Community: <input type="checkbox"/> Mercy: <input type="checkbox"/> Signature: <input type="checkbox"/> Southcoast: <input type="checkbox"/> Other: _____		
Panel open? Y: <input type="checkbox"/> N: <input type="checkbox"/> Open for established Patients only? Y: <input type="checkbox"/> N: <input type="checkbox"/> Are you certified to provide Medication-Assisted Treatment (MAT) through the Substance Abuse and Mental Health Services Administration (SAMHSA)? Y: <input type="checkbox"/> N: <input type="checkbox"/>		
Please complete the section below to indicate whether the provider will serve the special populations listed below. Please note: The Commonwealth of Massachusetts requires us to collect this information.		
Accessibility to Services		
	Yes	No
American Sign Language	<input type="checkbox"/>	<input type="checkbox"/>
Adults with Severe Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Autism Services	<input type="checkbox"/>	<input type="checkbox"/>
Bilingual or Multi-lingual Abilities	<input type="checkbox"/>	<input type="checkbox"/>
Children and Adolescents	<input type="checkbox"/>	<input type="checkbox"/>
Children with Severe Physical Disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Patients (65+)	<input type="checkbox"/>	<input type="checkbox"/>
Homeless Patients	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS Patients	<input type="checkbox"/>	<input type="checkbox"/>
Visually Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Children in the Care or Custody of DCF or youth affiliated with DYS	<input type="checkbox"/>	<input type="checkbox"/>
Handicap Accessibility		

	Yes	No
Accessible Examination Table	<input type="checkbox"/>	<input type="checkbox"/>
Accessible Restrooms	<input type="checkbox"/>	<input type="checkbox"/>
Accessible Scales	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric Examination Tables	<input type="checkbox"/>	<input type="checkbox"/>
Bariatric Scale	<input type="checkbox"/>	<input type="checkbox"/>
Elevators in Multistory Buildings	<input type="checkbox"/>	<input type="checkbox"/>
Handicap Parking	<input type="checkbox"/>	<input type="checkbox"/>
Lifts (e.g. Hoyer)	<input type="checkbox"/>	<input type="checkbox"/>
Accessible via Public Transportation:	<input type="checkbox"/>	<input type="checkbox"/>
Signs in Braille	<input type="checkbox"/>	<input type="checkbox"/>
TTY for Member Services	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair ramps	<input type="checkbox"/>	<input type="checkbox"/>

Identify Additional Languages Spoken:

Supplier Diversity Information:

Are you a Minority owned business enterprise*? Y: N: N/A:

Are you Women owned business enterprise*? Y: N: N/A:

Are you a Veteran owned business enterprise*? Y: N: N/A:

Are you a LGBT owned business enterprise*? Y: N: N/A:

*Please provide a copy of your certification with this data form.

Do you wish to be included in the BMC HealthNet Plan Provider Directory? Y: N:

Additional documents to submit to BMC HealthNet Plan:

Participating Provider Agreement (if not contracted)

W-9 Form

HCAS Enrollment Form (including covering physician information)

Abbreviated Credentialing Form (Locum Tenen)

Additional practice addresses and office hours if there are more service locations than listed on the HCAS Enrollment Form. Please attach an additional sheet if needed.