BOSTON MEDICAL CENTER
HEALTHNet PLAN

BMC HealthNet Plan Provider Data Form

Please note: An incomplete form may result in delayed credentialing. **Today's Date_____**

Provider Demographics	
Provider Name:	☐PCP ☐Hospital Based ☐Specialist ☐Locum Tenen *Please complete Locum Tenen Credentialing Form
Provider Title:	
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:	☐Community Health Center ☐Rural Health Center ☐Federally Qualified Health Center
Collaborating MD (include PAs and NPs):	

Is provider a PCP? Y: ☐ N: ☐	Gender served: M: ☐ F: ☐	Are there age restrictions? Y: ☐ N: ☐
Panel open? Y: ☐ N: ☐	Open for established Patients only? Y: ☐ N: ☐	

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	☐	☐
Adults with Severe Physical Disabilities	☐	☐
Autism Services	☐	☐
Bilingual or Multi-lingual Abilities	☐	☐
Children and Adolescents	☐	☐
Children with Severe Physical Disabilities	☐	☐
Geriatric Patients (65+)	☐	☐
Homeless Patients	☐	☐
HIV / AIDS Patients	☐	☐
Visually Impaired	☐	☐
Children in the Care or Custody of DCF or youth affiliated with DYS	☐	☐
Handicap Accessibility		
	Yes	**No**
Accessible Examination Table	☐	☐
Accessible Restrooms	☐	☐
Accessible Scales	☐	☐
Bariatric Examination Tables	☐	☐

Bariatric Scale	☐	☐
Elevators in Multistory Buildings	☐	☐
Handicap Parking	☐	☐
Lifts (e.g. Hoyer)	☐	☐
Accessible via Public Transportation:	☐	☐
Signs in Braille	☐	☐
TTY for Member Services	☐	☐
Wheelchair ramps	☐	☐
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.