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: Provider Title:	☐PCP ☐Specialist ☐Hospital Based ☐Locum Tenen	Mailing Contact Name: Mailing Contact E-mail: *Please complete Locum Tenen Credentialing Form
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	☐	☐

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: _____

Are you a minority owned business*? Y: ☐ N: ☐ N/A: ☐
*If you are a minority owned business, 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.