



HCAS Provider Enrollment Form

Please Fax only first 2 pages of this form to the health plan

DATE	COMPLETED BY	TELEPHONE/EMAIL OF PERSON COMPLETING FORM
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Provider Information

Provider First Name	Middle Initial	Provider Last Name	Degree/Title	Social Security Number	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>
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Provider Email Address: _____ Languages spoken: _____

Specialty: Board Certified? Yes No If you are not certified, are you eligible? Yes No If yes, exam date: _____

Sub Specialty: Board Certified? Yes No If you are not certified, are you eligible? Yes No If yes, exam date: _____

CAQH ID:	National Provider Identifier (NPI):	License #	DEA #:
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PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both <input type="checkbox"/> Hospitalist Only <input type="checkbox"/>				
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Provider Category: _____ Primary Hospital Affiliation: _____ Secondary Hospital Affiliation: _____ Staff Position: _____
If no hospital affiliation, provide admitting arrangements and MD name: _____

Nurse Practitioner Board Certificate number : _____ Provide collaborating MD For all NP's, PA's and APRN's: _____
Some emergency medicine, radiologists, anesthesiologists, or pathologists who practice exclusively within a facility and who do not receive direct referrals may qualify for an abbreviated process. Please check here if you meet the criteria.

Practice Information

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group. Use a separate page to list additional addresses.

Practice Name: _____

Address Primary Address Mailing Address Credentialing Address Additional Practice

Street: _____

City	State	ZIP Code	Languages Spoken by office staff
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Telephone:	Fax:	Email:	Practice Manager Name	Practice Start Date
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Provider email _____

Practice Name: _____

Address Primary Address Mailing Address Credentialing Address Additional Practice

Street: _____

City	State	ZIP Code	Languages Spoken by office staff
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Telephone	Fax	Email:	Practice Manager Name	Practice Start Date
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Practice Name: _____

Address Primary Address Mailing Address Credentialing Address Additional Practice

Street: _____

City	State	ZIP Code	Languages Spoken by office staff
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Telephone:	Fax:	Email:	Practice Manager Name:	Practice Start Date:
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Payment Information

Payee Name: _____

Tax Identification Number Group NPI #

Payment Address

Street _____

City _____ State _____ ZIP Code _____ Email _____

Telephone _____ Fax _____ Contact Name _____

Optional Practice Information

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Average Waiting Time to Schedule:

Initial Visit	Routine Physical	Urgent Visit
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Your Practice must provide 24 hour coverage. Do you have 24 hour coverage? Yes No

Please list Covering Providers or Group (attach additional sheet if necessary):

Name	Specialty	Provider Type	Phone Number

Handicap Access: Yes No

Practice Type: Solo Partnership Single Specialty Group Multi-Specialty Group Concierge Model Other: _____

Other Provider Information

Is the provider accepting new patients? Yes No

Does the provider participate in and meet the conditions of participation in Medicare? Yes No

Does the provider have a current, valid and active Medicare participating PTAN number? Yes No

If yes, please indicate participating PTAN number: _____

Please indicate Medicaid number: _____

Please list any practice restrictions for the provider: _____

What age groups do you treat? _____

Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes No

Describe the steps you take to monitor for and prevent discriminatory practices: _____

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Additional Documents to Submit: Please see *Health Plan Contracting and Enrollment Required Documents List* located on the Resources page of www.hcasma.org

HCAS provides access to this enrollment form for the convenience of HCAS member plans and their participating providers. HCAS makes no guarantee regarding the enrollment form and disclaims any responsibility for its accuracy, completeness or compliance with health plan requirements. Further, it is the responsibility of each provider to complete the enrollment form and distribute it to health plans according to health-plan specific policies and procedures, and HCAS disclaims any responsibility for making or communicating such information to health plans

Submission Information

<p>Blue Cross Blue Shield of MA Fax: 617-246-4227 Phone: 800-316-BLUE (2583)</p>	<p>Boston Medical Center HealthNet Plan Provider Processing Center 529 Main Street, Suite 500 Charlestown, MA 02129 BMCHP.providerprocessingcenter@bmchp.org Provider Processing Center: 888-566-0008 Fax: 617-897-0818</p>	<p>Fallon Community Health Plan One Chestnut Place 10 Chestnut Street Worcester, MA 01608 Fax: 508-368-9902 Email: askfchp@fchp.org Provider Services: 866-275-3247, Opt 4</p>
<p>Harvard Pilgrim Health Care Attn: Provider Processing Center 1600 Crown Colony Drive, 2nd Floor Quincy, MA 02169 Fax: 866-884-3843 Email: PPC@harvardpilgrim.org Provider Service Center: 800-708-4414</p>	<p>Health New England Provider Contracting One Monarch Place Suite 1500 Springfield, MA 01144 Fax: 413-233-2697 Email: provcred@hne.com Phone: 800-842-4464</p>	<p>Medical Network, Inc. (MedNet) (Maine and Southern NH Providers only) Credentialing Department PO Box 780 Scarborough, ME 04070 Phone: 207-289-1040 Ext 108 Fax: 207-289-1047 Email: CBelliveau@MaineMedNet.com</p>
<p>Neighborhood Health Plan Credentialing Department 253 Summer Street Boston, MA 02210-1120 Fax: 617-526-1982 Email: pec@nhp.org Provider Service Center: 855-444-4647 (4NHP)</p>	<p>Network Health 101 Station Landing, 3rd Floor Medford, MA 02155 Fax: 781-393-3121 Provider Contracting Service: 888-257-1985</p>	<p>Tufts Health Plan Credentialing Department 705 Mt Auburn Street, 6th Floor Watertown, MA 02472 Fax: 617-972-9591 Email: Your Credentialing Contact Phone: 888-306-6307</p>