HCAS Provider Enrollment Form

DATE	COMPLETED BY	TELEPHONE

Provider Information

Provider Name (First, Middle, Last, Suffix)	Degree/Title	Specialty	Subspecialty

CAQH ID	Social Security Number	Date of Birth	License #	DEA #	Gender: ☐M ☐F

National Provider Identifier (NPI)	Medicare/Medicaid #	Provider Category	Primary Hospital Affiliation	Staff Position
		☐PCP ☐ Specialist ☐ Both		

If no hospital affiliation, provide admitting arrangements including name of MD ___________________________________

Provide collaborating MD (NP only)____

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 this 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 Provider

Telephone	Fax	Email	Practice Manager Name	Practice Start Date

Address ☐ Primary Address ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice

Street

City	State	ZIP Code	Languages Spoken by Provider

Telephone	Fax	Email	Practice Manager Name	Practice Start Date

Address ☐ Primary Address ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice

Street

City	State	ZIP Code	Languages Spoken by Provider

Telephone	Fax	Email	Practice Manager Name	Practice Start Date

Payment Information

Payee Name:	Tax Identification Number	Group NPI #

Payment Address

Street

City	State	ZIP Code	Email

Telephone	Fax	Contact Name

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Optional Practice Information

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Average Waiting Time to Schedule:

Initial Visit	Routine Physical	Urgent Visit

Covering Physicians (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

Please list any practice restrictions for the provider: _____

What age groups do you treat? _____

Submission Information

Blue Cross Blue Shield of MA **Fax:** 617-246-4227 **Phone:** 800-316-BLUE (2583)	**Boston Medical Center HealthNet Plan** Provider Processing Center 2 Copley Place, Ste. 600 Boston, MA 02116 BMCHP.providerprocessingcenter@bmchp.org **Provider Processing Center:** 888-566-0008 **Fax:** 617-897-0818	**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
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	**Health New England** One Monarch Place Suite 1500 Springfield, MA 01144 **Fax**: 413-233-2808 **Phone**: 800-842-4464	**Medical Network, Inc. (MedNet)** Credentialing Department 59 Middle St. PO Box 15253 Portland, ME 04112 **Phone:** 207-773-5116 Ext 108 **Fax:** 207-773-1739 **Email:** CBelliveau@MaineMedNet.com
Neighborhood Health Plan Credentialing Department 253 Summer Street Boston, MA 02210-1120 **Fax:** 617-526-1982 **Email:** prweb@nhp.org **Customer Care Center:** 800-462-5449	**Network Health** 101 Station Landing, 3rd Floor Medford, MA 02155 **Fax:** 781-393-3121 **Provider Contracting Service:** 888-257-1985	**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

Additional Documents to Submit:

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