HCAS Provider Enrollment Form

DATE	COMPLETED BY	TELEPHONE

Provider Information

Provider Name (First, Middle, Last, Suffix)	Degree/Title	Specialty/Sub-specialty

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

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

Please complete a separate page for all new enrollees in the group. Use a separate page to list additional addresses.

Practice Information

Practice Name _____

Primary Practice Office _____
Street

City | State | Zip Code | Languages Spoken by Provider

Telephone | Fax | Email | Practice Manager Name

Additional Address _____ ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice
Street

City | State | Zip Code | Languages Spoken by Office Staff

Telephone | Fax | Email | Contact Name

Additional Address _____ ☐ Mailing Address ☐ Credentialing Address ☐ Additional Practice
Street

City | State | Zip Code | Languages Spoken by Office Staff

Telephone | Fax | Email | Contact Name

Payment Information

Payee Name _____ Tax Identification Number

Payment Address _____
Street

City | State | Zip Code | Email

Telephone | Fax | Contact Name

If the provider listed above is an Emergency Medicine, Radiologist, Anesthesiologist or Pathologist, does he/she practice exclusively in a facility setting or facility-based ER? ☐Hospital ☐Free-standing Facility ☐No

Does he/she accept direct referrals from clinicians? ☐Yes ☐No

Does he/she need to be listed in directories? ☐Yes ☐No

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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 401 Park Drive Mail Stop 03-04 Boston, MA 02215-3326 **Provider Relations**: 800-316-2583	**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**: 413-734-8140 **Phone**: 800-842-4464	**Neighborhood Health Plan** Credentialing Department 253 Summer Street Boston, MA 02210-1120 **Fax:** 617-526-1982 **Email:** credentialing@nhp.org **Customer Care Center:** 800-462-5449	**Network Health** Network Management 432 Columbia Street Cambridge, MA 02141 **Fax:** 617-806-8530 **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 (as applicable per Health Plan requirements):

W-9

Contract/Joinder

Addendum for Scope of Practice (Nurse Practitioners in NH/ME) – HPHC only

Behavioral Health Clinical Profile (Behavioral Health Providers) – BCBS only

General Anesthesia Permit/Anesthesia Facility Permit D (Oral Surgeons) – BCBS only

Delineation of Psychopharmacology Privileges (Clinical Nurse Specialists) – BCBS only

Collaborating Physician Name and Two Letters of Reference (Nurse Practitioners) – BCBS only