MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Letter of Intent for Durable Medical Equipment and Supplies

If you are applying to enroll as a MassHealth provider of durable medical equipment (DME) and medical supplies, or if you are currently enrolled with MassHealth as a pharmacy provider or oxygen and respiratory therapy equipment provider, and are requesting a DME specialty for your existing MassHealth provider file, you must submit a Letter of Intent (LOI) (see below). In accordance with 130 CMR 409.404, you must submit the LOI to MassHealth before receiving and completing a MassHealth provider application for DME. You must submit a separate LOI for each service facility for which you are applying to become a MassHealth DME provider, or for which you are requesting a DME specialty. Submit your completed and signed LOI to the following address

MassHealth
Attention: Provider Enrollment and Credentialing
P.O. Box 9162
Canton, MA 02021

MassHealth may request additional information from the applicant after receiving the completed LOI form. MassHealth must receive a fully completed LOI from the applicant within 14 calendar days of the applicant's request to enroll as a MassHealth DME provider. If any information on the LOI needs further clarification, or is not deemed sufficient, a notification will be sent to the applicant requesting the additional information be sent to MassHealth, within 10 business days of the date of the notification. Please note that MassHealth cannot process a provider application for DME until a fully completed LOI is received. Once the completed LOI is received by MassHealth, the applicant will receive a letter from MassHealth acknowledging receipt of the LOI and informing the applicant to proceed with submitting a provider application to MassHealth.

Please Note: If you are planning to provide home infusion services, you must first enroll as a MassHealth pharmacy provider. This must be done before submitting an LOI and application to MassHealth to provide DME services.

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1. Applicant's tax ID no.: _____

   Legal entity name: _____

   Legal entity address: _____

   Doing business as (DBA) name: _____

   DBA address (i.e., service facility address): _____

   Contact name: _____ E-mail address: _____

   Phone no.: _____ Fax: _____

   If you are currently enrolled as a MassHealth provider, list all your MassHealth provider ID nos.:

   _____

   _____

   _____

2. What is your organization/company's current primary scope of business (i.e., mobility equipment and accessories)?

   _____

   _____

   _____

3. Do you have a pharmacy license? ☐ Yes ☐ No If yes, license no.: _____

   Note: Except for specialty providers described in 130 CMR 409.404(D), the applicant (and if it becomes a provider, the DME provider) must primarily engage in the business of providing DME or durable medical equipment repair services to the public. For example, ***an applicant or provider with a pharmacy license would not be considered primarily engaged in the business of providing DME.***

4. What DME services, equipment, and/or medical supplies do you intend to provide to MassHealth members?

5. List the address for each service facility location operated by your organization/company.

6. List the service facility DBA address for which this LOI applies and for which you are applying to be a MassHealth provider of DME.

   Note: DME regulations at 130 CMR 409.404(C)(2) require separate approval from MassHealth, and a separate provider number for each service facility DBA address operated by the provider.

7. Describe the geographical area(s) in which you intend to provide the above services.

8. Do you intend to use a subcontractor(s)? ☐ Yes ☐ No

9. If you answered "Yes" to question 8, provide the name and address of the subcontractor(s), and describe the specific services, equipment, or supplies for which you intend to subcontract. If you answered "No" to question 8, indicate N/A here.

10. List the existing contracts you have with other third-party payers. You must also update MassHealth immediately with any new, terminated, or expired contracts.

Attestation, Signature, and Date

I hereby certify under the pains and penalties of perjury that the information on this form, and any attachments that I have provided, have been reviewed and are true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. I have read the MassHealth regulations and understand and agree that it is my responsibility to be familiar and comply with the provisions of those regulations as they currently appear and as they may at any time be modified.

Signature of DME applicant: _____
(Signature and date stamps, or the signature of anyone other than the applicant or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of DME applicant: _____

Printed legal name and position/title of individual signing: _____
(if the applicant is a legal entity)

Contact information of individual signing:

Address: _____ E-mail: _____

Phone: _____ Fax: _____

Date: _____