



HCAS Provider Enrollment Form

DATE	COMPLETED BY	TELEPHONE
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Provider Information

Provider Name (First, Middle, Last, Suffix)			Degree/Title	Specialty/Sub-specialty
CAQH ID	Social Security Number	Date of Birth	License #	DEA # Gender: <input type="checkbox"/> M <input type="checkbox"/> F
National Provider Identifier (NPI)	Medicare/Medicaid #	Primary Hospital Affiliation	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Both Staff Position	

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 _____

Street			
City	State	Zip Code	Languages Spoken by Office Staff
Telephone	Fax	Email	Contact Name

Additional Address _____

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

<p>Blue Cross Blue Shield of MA 401 Park Drive Mail Stop 03-04 Boston, MA 02215-3326 Provider Relations: 800-316-2583</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 One Monarch Place Suite 1500 Springfield, MA 01144 Fax: 413-734-8140 Phone: 800-842-4464</p>	<p>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</p>	<p>Network Health Network Management 432 Columbia Street Cambridge, MA 02141 Fax: 617-806-8530 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>	

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