



# **MassHealth**

## **Provider Enrollment Overview**

### **– Individual Pay Providers**

Executive Office of Health & Human Services

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# MassHealth Provider Manual



The Provider Manual is a tool that providers should reference for the compliance of MassHealth regulations, to understand administrative and billing instructions, to confirm covered service codes, and gain an understanding of the MassHealth processes. You can find a list of MassHealth provider manuals online.

You should access the Provider Manual and review the provider specific regulations to help you decide if offering services to MassHealth members is right for you.

The provider manual may be accessed at the following

<https://www.mass.gov/lists/masshealth-provider-manuals#how-to-read-your-provider-manual->

The Executive Office of Health and Human Services (EOHHS) establishes rates for MassHealth services, which may be found at <https://www.mass.gov/service-details/ehhss-regulations>.

# POSC Enrollment



The Provider Online Service Center (POSC) is the preferred method for submitting provider enrollments (as well as for file maintenance)

All enrollments except Ordering, Referring and Prescribing only providers (ORP providers) can be submitted via POSC

Any enrollment documents may be attached to the POSC enrollment

For this presentation, we will be going over the paper version of the enrollment (the advice that we provide will be relevant for both online and paper enrollments)

# Enrollment Documents



In addition to the **Provider Application for Medical Practitioners (March 2023 edition)**, the following documents are Required For All Providers:

- Provider Enrollment Data Collection Form and Registration Instructions (“DCF”, June 2023 edition)
- Federally Required Disclosures form for Individual Practitioners (“FRDF”, March 2023 edition)
- MassHealth Provider Contract for Individuals (November 2015 edition)

Required only if the provider is going to be paid directly for services (Pay Provider):

- Electronic Funds Transfer (EFT) Enrollment/Modification Form (March 2023 edition)
- Electronic Remittance Advice Enrollment/Modification Form (“ERA”, March 2023 edition)
- Massachusetts Substitute W-9 Form (“W-9”, March 2020 edition)
- Trading Partner Agreement (TPA, December 2021 edition)

You can use [this link](#) to access the Mass.gov page where many of the above forms can be downloaded for free. Other forms may be required and would be included in your packet if you requested an Application by phone

# Tips for Completing Enrollment



- **MassHealth strongly recommends that enrollments be submitted via POSC.** If applications are not submitted via the POSC, always request the application forms packet by calling the MassHealth Customer Service Center at 1-800-841-2900 to ensure that you have the most up to date forms.
- **A provider is NOT an approved MassHealth Provider until they receive a MassHealth Welcome Letter with a Provider ID and Service Location (PID/SL) and an effective date.** Welcome letters are mailed to the DBA address listed on the application.
- **Claims will not be paid for dates prior to the MassHealth assigned effective date.** MassHealth does not backdate the effective dates of any applications.
- Ensure that the contact person you list at the beginning of the application is ready and willing to correspond with MassHealth about the Enrollment. In particular, this person should know not to include any personally identifiable information (PII) in any of their emails to us as this represents a risk to Provider privacy.
- All fields must be completed; Nothing should be left unanswered or blank unless it is explicitly stated that a particular section of a document can be left blank.

# Tips for Completing Enrollment



- The Provider's information (primary service location, provider name, FEIN, account numbers, and NPI) must be consistent across all forms
- To ensure that a provider is successfully enrolled for a desired effective date, please submit the application at least 30 days in advance of that date and include a letter of intent stating the desired effective date
- Effective 10/02/2023, electronic signatures (e-signatures) are acceptable on ALL MassHealth forms
- A provider can sign MassHealth forms in any of the following ways:
  - Traditional hand-drawn signature (ink on paper)
  - Electronic signature that is either:
    - Hand drawn using a mouse or finger if working from a touch screen device
    - An uploaded picture of the signatory's hand drawn signature
  - Electronic signatures affixed using a digital tool such as Adobe Sign or DocuSign. A digital signature certification must be included with the signature.
- Please Note: Typed text of a name not generated by a digital tool such as Adobe Sign or DocuSign, even in computer-generated cursive script, or an electronic symbol, are not acceptable forms of electronic signature.

# Top Enrollment Errors



Provider Application (ORP and FFS)	FFS Provider Application (Billing)	Provider Contract (Nonbilling & Billing)	FRDF for Individuals
DEA number on application is not registered in MA <u>but the address listed is an MA address</u> . Your DEA must be registered to the state where you practice	Application has inconsistent versions on different pages (Confirm the revision date on the bottom left)	Contract has provider's signature in the wrong field (signature in EOHHS field)	Address in Section 1 does not match home address in Section 1.2 of Billing Application
Provider license cannot be verified <u>but no indication of license pending and/or anticipated license issue date</u> . Applications will be put on hold until a license is issued and confirmed by the provider.	Provider does not have a MA-registered DEA and no statement of DEA Waiver	Contract signature date not within 90 days of the date MassHealth received the application	Primary Service Location (PSL) street address in Section 2 does not match the address of the first group listed in Section 3.1 of Billing Application
Applying intern or resident without a submission of their limited license	The group that is the provider's PSL is not listed first on Section 3 of the application	Contract has white-out or cross-outs	"DBA Name" in Section 2 is blank (should be "NONE" if the provider is not enrolling with a group)
Disclosure sections are blank or incomplete	Group is enrolling concurrently with individual, but no group application was submitted	Name on Contract does not match the name on the provider's license	Section 3 does not reflect all the tax-IDs that the provider is requesting to link to in Section 3.1 of Billing application as "Agent"
Provider PID/SL is enrolled with MassHealth, but either no PID/SL or an incomplete PID/SL is listed	All or some of the three questions in Section 4 (Applicant Disclosures) are blank	Revision date of the contract is out of date	Section 4A is blank or is not consistent with the answers given in Section 4 of the Billing application

# Waiting For Information/Outreach

We will reach out to the person listed in the contact information on the Application if we have any questions. Please ensure that this person is able to answer all questions about the enrollment.

If an enrollment cannot be completed due to missing, incorrect, or incomplete information, then the enrollment will be put on hold and the Provider Services staff will conduct the following outreach:

1. The PEC Specialist outreaches to the contact's name listed on the application via phone, email, and a letter
2. If no response is received within 5 days, we will attempt a second outreach via phone and an email to the contact person on the application
3. If no response is received within two days after the second attempt, the staff repeats the call and sends another email

The 2-day outreach process continues until the issue is resolved or until the enrollment process reaches day 60.

**Note: The faster a provider responds to an outreach request, the faster the enrollment can be processed.**



# Overview of the Enrollment Process

*“How do I submit all of the necessary Enrollment documents once they are all ready?”*

- Upload the completed and signed documents to the attachments panel on the POSC for enrollments initiated on the POSC.

OR

Fax to: 617-988-8974

OR

Mail to:

MassHealth Provider Enrollment and Credentialing  
P.O. Box 278  
Quincy, MA 02171-0278

Note: Some MassHealth documents list a P.O. Box in Boston as the mailing address. The Boston P.O. Box is inactive as of 1/1/2023 and any reference to it should be ignored. We are in the process of updating all our documents to list the correct P.O. Box in Quincy.

# Provider Enrollment

## Document Instructions

# Provider Enrollment Document Instructions

The following are detailed, step-by-step instructions for filling out the paper versions of following documents:

- **The Provider Application Form**
- **The Provider Enrollment Data Collection Form**
- **The Federally Required Disclosures Form (FRDF)**
- **The Electronic Funds Transfer Form (EFT)**
- **Massachusetts Substitute W-9 Form (W-9)**

We will not be going over the Contract or Trading Partner Agreement in this presentation

# Provider Application Form

# Overview of the App – Page 1



**MassHealth**

**PROVIDER APPLICATION**  
MEDICAL PRACTITIONER

Commonwealth of Massachusetts | Executive Office of Health and Human Services | [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

This application will not be processed if any sections are left unanswered.

**CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS APPLICATION** (MassHealth may contact you if there are questions about this application.)

Name \_\_\_\_\_ Tel. \_\_\_\_\_  
Email \_\_\_\_\_

**REASON FOR APPLICATION**

New enrollment  
 Reactivation – Provider ID Service Location (PIS/SL) \_\_\_\_\_

**SECTION 1: APPLICANT INFORMATION**

**1.1 APPLICATION TYPE**

Is the applicant enrolling as  
 An individual practitioner practicing independently  Part of a group practice organization  Both

Note: This application is for individual practitioners of the provider types listed below, who practice independently or as part of a group practice, and who wish to enroll as a participating MassHealth practitioner. This application should not be completed by other salaried or contracting providers, ordering and referring applicants, or managed care entities (MCE) applicants.

Please indicate your provider type below (select one).

Physician (PT-01)\*  Certified Nurse Practitioner (PT-17)\*  Psychiatric Clinical Nurse Specialist (PT-78)  
 Optometrist (PT-02)  Physician Assistant (PT-39)  Qualified Medicare Beneficiary (QMB) Only Provider (PT-86) (Cannot be part of a Group Practice Organization)  
 Optician (PT-03)  Hearing Instrument Specialist (PT-44)  Acupuncturist (PT-A9)  
 Ocularist (PT-04)  Audiologist (PT-50)  Certified Registered Nurse Anesthetist (PT-51)  Licensed Independent Clinical Social Worker (PT-92)  
 Psychologist (PT-05)  Clinical Nurse Specialist (PT-57)  
 Podiatrist (PT-06)  
 Certified Nurse Midwife (PT-08)  
 Chiropractor (PT-16)

\*These providers can enroll as independent PCCs; PCC-qualifying providers must specialize in: family medicine, internal medicine, pediatrics, OB/GYN, or GYN, and otherwise satisfy PCC Plan participation requirements.

Does the applicant wish to participate in the Primary Care Clinician (PCC) Plan?  Yes  No

Providers who are interested in enrolling in the PCC plan must submit a completed Primary Care Clinician (PCC) Plan Provider Application (APP-PCC) along with a Primary Care Clinician (PCC) Plan Signature Page CON-PCC-SP, and the PCC Contract.

PE-MP (Rev.03/23) | page 1 | PROVIDER APPLICATION: Medical Practitioner

## Contact Information

- Contact person's name, telephone number, and email address need to be accurate and complete
- If any clarifications or corrections are needed for the Application, then MassHealth will follow up with the individual listed in this section
- *Reason for Application:* For new enrollments, check off the "New enrollment box"

## Section 1: Applicant Information

- Indicate whether the Provider is applying as an individual practitioner practicing independently, a member of a group practice organization, or both by checking off the appropriate box
- Check off the appropriate box for the applicant's Provider Type (PT)
- Do not forget to check off the box at the bottom of the page to indicate if the applicant wishes to participate in the Primary Care Clinician (PCC) Plan. Do not leave this part of the Application blank.

# Overview of the App – Page 2



## Section 1.2: Applicant Information

1.2 APPLICANT INFORMATION		
Legal Name of Applicant: Last	First	Middle Initial
<input type="checkbox"/> Individual (SSN)	<input type="checkbox"/> Sole Proprietor ( <input type="checkbox"/> SSN or <input type="checkbox"/> EIN)	
Applicant's National Provider Identification (NPI)	Date of Birth	
Applicant's Professional License Number (MA)	State/License Number	
<input type="checkbox"/> DEA Number (if issued)	<input type="checkbox"/> Do not have a DEA in practice state	<input type="checkbox"/> Check box if prescribing only Schedule VI drugs
Applicant Legal Address/Home Street Address		
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

- The Provider's full legal name (L/F/M). Name must match across all forms and the license board and NPPES. If names are different, please provide supporting documentation to explain the discrepancy.
- Full SSN (Indicate if you are an individual or sole proprietor and list the SSN in the appropriate field)
  - You may list an FEIN if the Provider is a sole proprietor (check off the appropriate box if so). The Provider's SSN must be still listed on the FRDF
- NPI
- DOB
- Professional or State License Number
- DEA number (if applicable. Providers that do not prescribe medications need not list a DEA number and must write "N/A" instead)
- The Provider's residential Home Address (street/city/state/zip)
- Provider's email, telephone, and fax (if you use a fax machine)

# Overview of the App – Page 2 (Cont.)



1.3 MEDICAID INFORMATION FOR OTHER STATES	
Does the applicant currently participate, or has he or she previously participated, in another state's Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Other State	Medicaid Number
Effective Date	End Date (if applicable)
List Other State	Medicaid Number
Effective Date	End Date (if applicable)
List Other State	Medicaid Number
Effective Date	End Date (if applicable)
1.4 CERTIFIED SPECIALTY	
Board Certifications (as certified by your board of professional licensure)	
Area of Certifications (if applicable)	
Other Area of Certifications (if applicable)	
1.5 MEDICARE INFORMATION	
Is the applicant enrolled in Medicare as a provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In process	

MassHealth requires Medicare enrollment for any provider that files claims for services provided to MassHealth members who are also enrolled in Medicare (dual eligible members). Please refer to MassHealth's all-provider regulations and all applicable program-specific regulations. You can access these publications from the MassHealth website at [www.mass.gov/masshealth-and-eohhs-regulations](http://www.mass.gov/masshealth-and-eohhs-regulations).

## Section 1.3 Medicaid Information For Other States

- Indicate if the Provider is a current or previous participant in the Medicaid program of any other US state by listing the state, Medicaid number, and (approximate) effective dates of each program.
- If the Provider is not or never was a participant in any other Medicaid program, then do not leave this section blank; Check off the box labeled "No"

Indicate the Provider's certified specialty in this section

Indicate if the Provider is enrolled in Medicare as a Provider or if they are in process to become a Medicare Provider in the future.

# Overview of the App – Page 3



## SECTION 2: INDIVIDUAL PRACTITIONER PRACTICING INDEPENDENTLY

Note: This section applies ONLY to individual practitioners practicing independently and practitioners BOTH practicing individually AND as part of a group practice organization. If applying to participate ONLY as part of a group practice organization, please proceed to Section 3.

### 2.1 ELECTRONIC FILE SUBMISSION METHOD

Please indicate which transactions will be submitted electronically and what method will be used to transmit electronic files. (With limited exceptions, MassHealth does not accept paper claims (see 130 CMR 450.302). You must submit a Trading Partner Agreement (TPA) if completing this section.

**TRANSACTION TYPES:** Check the type of transaction that the applicant will be submitting and/or receiving. Also check who will be submitting and/or receiving on behalf of the applicant and how they will be submitting and/or receiving the transactions.

Transaction Type	Who is submitting/receiving		Indicate the method being used	
	Applicant	Practice	Vendor	DDE*
<input type="checkbox"/> 835 Health Care Claims Payment/Advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 837P Professional Health Care Claim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 837P COB Professional Health Care Claim for Secondary Insurer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 270 Health Care Eligibility Benefit Inquiry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 271 Health Care Eligibility Benefit Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 276 Health Care Claims Status Request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 277 Health Care Claims Status Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VOID and/or REPLACE claims	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* DDE = Direct Data Entry  
\*\* EDI = Electronic Data Interchange

**VENDOR INFORMATION:** If you checked the "Vendor" box one or more times in the preceding "transaction types" section, you must complete this section.

Check the box that describes the vendor:  Billing Intermediary  Clearing House  Software Vendor

In order for the vendor to submit transactions on your behalf, the vendor must also be an approved MassHealth provider with a valid MassHealth provider ID.

Vendor Name

Doing Business As (DBA) Name (if applicable)

MassHealth PIDSL Number (if applicable)

Vendor Contact Name

Vendor Tel.

Vendor Email

Note: Vendors must apply for a MassHealth relationship entity number before they can submit claims on behalf of the applicant. For more information, email MassHealth at [edi@mahealth.net](mailto:edi@mahealth.net).

### 2.2 BILLING ADDRESS (Address of the entity that submits claims)

Is the billing address the same as the legal address in Section 1.2?  Yes  No

If Yes, you do not have to complete the remainder of Section 2.2.

Number/Street	Building, Suite, or PO Box if applicable	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

**Section 2 of the Application is spread across pages 3 and 4. It applies ONLY to individual practitioners practicing independently and practitioners practicing BOTH individually AND as part of a group practice. If applying to participate ONLY as part of a group practice organization, then you can leave pages 3 and 4 completely blank and skip up to Section 3 on page 5**

# Overview of the App – Page 4



## 2.3 SERVICE LOCATION (SL) INFORMATION (Correspondence will be mailed to this address.)

Enter the applicant's street address, and all other information requested below that is applicable to this service location (SL) where services will be provided to MassHealth members. Post-office box (PO box) addresses are not acceptable. Enrollment will not be approved if only a PO box address is entered in this space.

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

## 2.4 OTHER SERVICE LOCATION (SL) INFORMATION

NUMBER  OF

PLEASE MAKE A COPY OF SECTION 2.4 IF YOU NEED TO LIST MORE THAN FIVE SERVICE LOCATIONS.

Note: Failure to list on the application all locations where services will be provided to MassHealth members is a violation of MassHealth regulations at 130 CMR 450.222 and 450.223. Please attach each completed copy of Section 2.4 to the signed application. Each such copy will become part of the application.

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

Number/Street	Building, Suite (if applicable)	
City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

Follow the instructions for  
**Sections 2.3 and 2.4**

Make sure to NOT use PO Boxes for  
any of the addresses listed in  
Section 2.4.

# Overview of the App – Page 5



## SECTION 3: GROUP AFFILIATION

NUMBER  OF

This section applies ONLY to applicants seeking to participate with a group practice organization currently enrolled with MassHealth or a group practice organization that is concurrently applying to enroll with MassHealth. Note: Applicants enrolling ONLY with a group practice organization do not need to submit a W-9, EFT, TPA, or ERA, as the group practice organization will be paid for services performed by the individual medical practitioner.

PLEASE MAKE A COPY OF SECTION 3 IF YOU NEED TO LIST MORE THAN FOUR GROUP AFFILIATIONS.

Please attach each completed copy of Section 3 to the signed application. Each such copy will become part of the application.

### 3.1 GROUP AFFILIATION

List the name(s) of each MassHealth-participating group practice organization, the NPI, and the MassHealth Provider ID and the Service Location (PID/SL). The first group practice organization listed will serve as the Primary Service Location.

Group Practice Organization Name

Check here if group practice organization enrollment is pending or is being submitted concurrently.

Group Practice Organization NPI  MassHealth PID/SL

Group Practice Organization Address (number/street)

City  State  Zip

Group Practice Organization Name

Check here if group practice organization enrollment is pending or is being submitted concurrently.

Group Practice Organization NPI  MassHealth PID/SL

Group Practice Organization Address (number/street)

City  State  Zip

Group Practice Organization Name

Check here if group practice organization enrollment is pending or is being submitted concurrently.

Group Practice Organization NPI  MassHealth PID/SL

Group Practice Organization Address (number/street)

City  State  Zip

Group Practice Organization Name

Check here if group practice organization enrollment is pending or is being submitted concurrently.

Group Practice Organization NPI  MassHealth PID/SL

Group Practice Organization Address (number/street)

City  State  Zip

Follow the instructions for  
Sections 3 and 3.1

Make sure to NOT use PO Boxes for  
any of the addresses listed in  
Section 3.1.

# Overview of the App – Page 6



## SECTION 4: APPLICANT DISCLOSURES

### 4.1 CRIMINAL CONVICTION(S) INFORMATION

Has the applicant ever been convicted of any state or federal crime in Massachusetts or any other state in the U.S., including but not limited to any criminal offense relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act (i.e., Medicare, Medicaid, or CHIP)?

Yes  No

If Yes, provide the following information for each such conviction. Note: Convictions for criminal offenses other than offenses relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act may be omitted if such conviction(s) 1) occurred more than 10 years before the date of this application, or 2) were punishable by imprisonment of less than one year, regardless of the date of such conviction.

Name of the Offense

Date of Conviction	Court/State	Case or Record Number
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Name of the Offense

Date of Conviction	Court/State	Case or Record Number
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Name of the Offense

Date of Conviction	Court/State	Case or Record Number
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### 4.2 SANCTION(S) INFORMATION

Has the applicant ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without consent by any state (including Massachusetts) or federal agency, board, or other regulatory/licensing agency including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, remedial training, or other educational or public service activities?

Yes  No

If Yes, for each such action provide the following information.

Agency or Board	Action Taken	Date of Action
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Agency or Board	Action Taken	Date of Action
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Agency or Board	Action Taken	Date of Action
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### 4.3 PENDING PROCEEDINGS

Is the applicant subject to any proceeding(s) currently pending that could result in a conviction, sanction, or other action reportable in Sections 4.1 or 4.2?

Yes  No

If Yes, provide the following information for each such proceeding.

Court/State, Agency, or Board	Case or Record Number
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Charge or Allegation	Case or Record Number
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Court/State, Agency, or Board	Case or Record Number
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Charge or Allegation	Case or Record Number
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Disclose any Criminal Convictions, Sanctions, or Pending Proceedings involving the Provider in Section 4.

Even if there is no information to disclose, do NOT leave any part of Section 4 blank; Check off the “No” boxes in each section.

# Overview of the App – Page 7



#### 4.4 ADDITIONAL EXPLANATION

The applicant may use the space below to provide additional information regarding the applicant's answers in Sections 4.1, 4.2, or 4.3. Attach additional pages if necessary.

Provide a detailed explanation of any Criminal Convictions, Sanctions, Or Pending Proceedings in **Section 4.4.**

You may attach supporting documentation to the Application to help give extra context details to the explanation.

# Overview of the App – Page 8



## SECTION 5: CERTIFICATION

### PLEASE READ CAREFULLY AND SIGN

I certify that I am a medical practitioner applying to enroll as a participating provider in MassHealth.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments 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, and that the failure to provide true, accurate, and complete information in this provider application may result in the denial of my enrollment as a participating provider in MassHealth or the termination of any provider agreement resulting from or related to this provider application. I understand that I must notify the MassHealth Provider Enrollment unit of any change in any of the information submitted in this Provider Application, and its attachments in accordance with and within the time specified in 130 CMR 450.223(B).

I hereby authorize MassHealth and its designees to access, and I agree to furnish to MassHealth upon request, any information MassHealth deems relevant to my eligibility and qualifications to be a participating provider in MassHealth, including otherwise privileged or confidential information. I understand and agree that I have the burden to produce adequate information to MassHealth to permit evaluation of my eligibility and qualifications to be a participating provider in MassHealth, and for resolving any doubts that MassHealth may have about my eligibility and qualifications.

The Applicant hereby releases from any liability MassHealth and all representatives of MassHealth for any acts performed in good faith in connection with the evaluation of the Applicant's eligibility and qualifications to be a participating provider in MassHealth.

I understand that I am obligated to cooperate with MassHealth during this application process, any revalidation of enrollment (including, but not limited to, revalidation required by Section 6401 of the Affordable Care Act and occurring at least every five years), or other review process.

Printed Legal Name of Applicant

Signature of Applicant

Date

Note: Signature and date stamps, or the signature of anyone other than applicant, are not acceptable.

Return your completed application packet by fax or mail to MassHealth.

Fax:  
(617) 988-8974

Mail:  
MassHealth Provider Enrollment and Credentialing  
PO Box 278  
Quincy, MA 02171-0278

If you have any questions about the enrollment process, please email PEC@Maximus.com. For general questions, you may contact MassHealth by email at provider@masshealthquestions.com. Please note: These email boxes are only for general questions. They are not secure. Please do not send documents to these email boxes, or include any personal health information (PHI) or personally identifiable information (PII). You may also call (800) 841-2900, TDD/TTY: 711.

Print

Clear

Complete the Application by signing the Certification Statement in Section 5. The Statement must be signed by the Provider, but the printed legal name and signature date can be added by another person.



# **The Provider Enrollment Data Collection Form (DCF)**

# Overview of the DCF



*“Why do I have to fill out a Data Collection Form?”*

MassHealth requires Providers to have at least one designated person who can access the Provider Online Service Center (POSC) on the Provider's behalf, known as the Primary User.

In the case of an individual Provider, This will usually be someone other than the Provider themselves.

The Primary User will be responsible for several functions, such as submitting information updates regarding the Provider and verifying their program eligibility and group linkage

# Overview of the DCF



- On Page 1, Check off the box on the left to establish a new Primary User
- Fill out all the Primary User's information in the fields marked with an asterisk
- You can come up with your own 4-digit PIN number

Please complete this form to obtain a User ID and password for the Primary User. Once the Primary User is registered, that person will need to create subordinate IDs for all other users within your organization and authorize access for business partners, such as billing agencies. The Primary User must assign a backup Primary User to perform Primary User responsibilities in the Primary User's absence.

**Please note:** It is important to ensure that access to your data is securely managed by the Primary User.

To confirm the Primary User Assignment, please select one of the two following options\*:

Establish a Primary User for this new service location  
 Assign an existing Primary User to this new service location

All fields marked with an asterisk (\*) are required fields that must be completed by the submitter.

Provider type:  PACE  SCO  Billing agency  All others

Provider's Name\*

Primary User's Last Name\*

Primary User's First Name\*

Middle Initial

Month and Date of Birth\* (MM/DD)

User-Defined Unique Four-Digit PIN\*

Work Zip

Primary User's Work Email Address\*

Existing Virtual Gateway User ID (if applicable)

Primary User's Contact Phone Number

# Overview of the DCF



- At the Bottom of Page 1, The Primary User must sign their name in the field on the left
- The Provider must add their signature in the field to the right of the Primary User's signature.

I certify that the information on this form and any attached statement that I have provided have been reviewed and signed by me 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 further acknowledge that I will review and adhere to the Commonwealth's standards for user access to its systems, including upon initial sign-in, and that my organization will comply with all the Commonwealth's standards for user access to its systems.

Provider's Primary User signature

Date

Provider's signatory

Date

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

# The Federally Required Disclosures Form (FRDF)

# Overview of the FRDF



- The main purpose of the Federally Required Disclosures Form is to gather information about any individual or entity with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity)
- As required by 42 CFR § 455.104 under Title 42
- Full text of this regulation can be found here:  
<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.104>

# Overview of the FRDF – Page 1



**FEDERALLY REQUIRED DISCLOSURES**  
**INDIVIDUAL PRACTITIONERS**

Commonwealth of Massachusetts | Executive Office of Health and Human Services | [www.mass.gov/masshealth](http://www.mass.gov/masshealth)

**Please ensure that all sections of this form are completed before submission.**

Federal law requires that individual practitioners providing or seeking to provide services to MassHealth members disclose certain information to MassHealth. See 42 CFR §§ 455.100–106, 42 CFR 455.436, and 42 CFR § 1002.3. MassHealth requires the submission of tax identification numbers (TINs), e.g., social security numbers (SSNs) or employer identification numbers (EINs), for purposes necessary to properly administer the MassHealth program (see 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405(c)(1)). Unless otherwise instructed by MassHealth, individual practitioners must use this form when disclosing such information to MassHealth.

**SECTION 1: PRACTITIONER INFORMATION**

Legal Name of Practitioner: Last	First	Middle Initial				
Date of Birth	National Provider Identifier Number (NPI)					
Home Street Address						
City	State	Zip	-			
Tel.	-	-	Fax	-	-	
Email						
Preferred Contact Name (if different than above)						
Preferred Contact Email (if different than above)						
Tel.	-	-				
City	State	Zip	-			
Tel.	-	-	Fax	-	-	
Email						

- **Fill out Section 1 with the individual Provider's:**
  - Full legal name (L/F/M)
  - DOB
  - NPI
  - Full SSN
  - Residential Home Address (PO Boxes are NOT acceptable)
  - The provider's email
  - Contact person's name and email
- **Section 2 must be filled out with the following:**
  - DBA name and street address
  - if the Provider has no DBA then check of the box labeled **NONE**, do not leave Section 2 blank
  - If the Provider's PSL address is the same as their Home Address, then check of the appropriate box "Yes"

# Overview of the FRDF – Page 2



## SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

- i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the applicant;
- ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the applicant or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the applicant;
- iii. Is an officer or director of the applicant, if the applicant is organized as a corporation;
- iv. Is partner in the applicant, if the applicant is organized as a partnership;
- v. Is an agent of the applicant;
- vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the applicant or part thereof, or directly or indirectly conducts the day-to-day operations of the applicant or part thereof; or
- vii. Was formerly described in i through vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

The definitions applicable to this section are as follows:

- *Agent* means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice organization).
- *Immediate family member* means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- *Indirect ownership interest* includes an ownership interest through any other entities that ultimately have an ownership interest in the applicant (e.g., an individual has a 10 percent ownership interest in the applicant if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the applicant).
- *Member of household* means, with respect to a person, any individual with whom he or she is sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.
- *Ownership interest* means an interest in:
  - the capital, the stock, or the profits of the applicant; or
  - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the applicant.

**NONE** (if NONE, continue to Section 4)  Ownership/Controlling Interest (of 5% or more)\*  Managing Employee\*  Agent\*

Name of Individual (Last, First, Middle Initial) or Entity

NPI  % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City  State  Zip   -

SSN (if Individual)  Date of Birth  EIN (if Entity)

\*For definition and further explanation of these terms, please see the top of Section 3.

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE THAN THREE INDIVIDUALS OR ENTITIES OR ADDITIONAL ADDRESSES. NUMBER  OF  (All business, corporate, and P.O. boxes must be listed.)

Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

- You must disclose any business relationships described in **Section 3** at the bottom of page 2
- If you have a relationships to disclose, then list that person's:
  - Full Name
  - NPI (if applicable)
  - % of Ownership stake
  - Title
  - Residential Home Address/Business address (as appropriate)
  - Full SSN or EIN
  - DOB (if applicable)
- Do NOT leave Section 3 blank. If there are no relationships to disclose, check the box labeled "NONE"

# Overview of the FRDF – Page 3



<input type="checkbox"/> Ownership/Controlling Interest (of 5% or more)*	<input type="checkbox"/> Managing Employee*	<input type="checkbox"/> Agent*											
Name of Individual (Last, First, Middle Initial) or Entity													
NPI	% of Ownership (if 5% or more)												
Title, Function, or Relationship to Practitioner													
Address (Home Address if Individual; Business Address if Entity)													
City	State	Zip	-										
SSN (if Individual)	Date of Birth		EIN (if Entity)										
<input type="checkbox"/> Ownership/Controlling Interest (of 5% or more)*	<input type="checkbox"/> Managing Employee*	<input type="checkbox"/> Agent*											
Name of Individual (Last, First, Middle Initial) or Entity													
NPI	% of Ownership (if 5% or more)												
Title, Function, or Relationship to Practitioner													
Address (Home Address if Individual; Business Address if Entity)													
City	State	Zip	-										
SSN (if Individual)	Date of Birth		EIN (if Entity)										
* For definition and further explanation of these terms, please see the top of Section 3 above.													
<b>SECTION 4: DISCLOSURES</b>													
For additional information, see 42 CFR § 455.106, 455.436, and § 1002.3, and 130 CMR 450.212.													
<b>4A. DISCLOSURE INFORMATION</b>													
Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer “yes” to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.													
1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													
2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													
3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													
4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													
5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													
6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in the immediately preceding questions 1-5?													
<input type="checkbox"/> Yes <input type="checkbox"/> No													

- If there is more than one business relationship to disclose for the provider, then list any other relationships on page 3.
- In **Section 4**, disclose any convictions or sanctions to which the Provider or any of the persons/entities listed in Section 3 may be subject.
- **Section 4** should NOT be left blank; If there are no disclosures to be made, check off the boxes labeled “No”

# Overview of the FRDF – Page 4



- If you answered “Yes” to any of the questions in Section 4, then give a detailed explanation of your answer(s) in **Section 4B**.
- You may attach supporting documentation to the FRDF to support your explanation
- Complete the FRDF by signing the Certification Statement in Section 5. The Statement must be signed by the Provider, but the printed legal name and date of signature can be added by another person.

# **The Electronic Funds Transfer Form (EFT)**

# Overview of the EFT

*“Why do I have to fill out an EFT?”*

MassHealth requires Providers who will be paid directly for their claims to fill out an EFT so that the program will know which bank account to deposit the payouts into. MassHealth does not issue paper checks for payment.

If the Provider will not be paid directly for their services to MassHealth patients at the service location listed on the Application, then you do NOT need to fill out an EFT.

# Overview of the EFT – Page 1



Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Office of Medicaid  
[www.mass.gov/masshealth](http://www.mass.gov/masshealth)

## Electronic Funds Transfer (EFT) Enrollment/Modification Form

Complete this form to enroll in electronic funds transfer (EFT) with MassHealth or to terminate or modify an existing electronic funds agreement. Additional terms of agreement on page 2 of this form must be completed.

**PROVIDER INFORMATION**

Provider legal name	DBA name		
Street	City	State	Zip

**PROVIDER IDENTIFIERS INFORMATION**

Provider TIN or EIN	NPI
---------------------	-----

**PROVIDER CONTACT INFORMATION**

Provider contact name		
Tel:	Tel. Ext.	Email

**FEDERAL AGENCY INFORMATION**

Federal program agency identifier
-----------------------------------

**FINANCIAL INSTITUTION INFORMATION**

Financial institution name			
Street	City	State	Zip
Financial institution routing number	Type of account at financial institution		
Provider's account number wth financial institution			
Provider TIN	NPI		

**SUBMISSION INFORMATION**

Reason for Submission	<input type="checkbox"/> New enrollment	<input type="checkbox"/> Change enrollment	<input type="checkbox"/> Cancel enrollment	<input type="checkbox"/> Included	<input type="checkbox"/> Voided check	<input type="checkbox"/> Bank letter
Signature of person submitting enrollment						
Printed name of person submitting enrollment	Submission date					

If you are modifying or changing your bank account information, you must include your old bank account information on page 2 of this form or your request will be incomplete.

### Provider Information - List the Provider's:

- Legal Name
- DBA name (if applicable)
- Residential Home Street Address, City, State, and Zip (do NOT list a PO Box)
- SSN in the "Provider TIN or EIN" field
- NPI number

### Provider Contact Information

- List the name, work phone number, and work email of the person filling out the EFT

### Financial Institution Information:

- List the name of the bank as it appears on its checks and/or bank letters
- The address (street/city/state/zip) of the specific bank branch
- The bank's Routing Number
- The type of financial institution
- The Provider's Account Number with that institution
- Repeat the Provider's SSN and NPI (make sure these match the SSN and NPI included above)

### Submission Information:

- Check off the appropriate box (usually "New Enrollment")
- Include a voided check or letter from your bank to confirm the bank routing and routing numbers (at least one is required)
- The signature of the Provider who is being enrolled in MassHealth
- Printed name of the person submitting the enrollment
- Submission Date

# Overview of the EFT – Page 2



Please complete page 2 in its entirety.

If you are modifying your bank account information, please provide the old bank account information directly below.

Provider old bank account number \_\_\_\_\_ Account type  Checking  Savings

## CERTIFICATION

I, \_\_\_\_\_, hereby certify that the account(s) indicated on this form is under my direct control and access; therefore, I authorize the state treasurer as fiscal agent for the Commonwealth of Massachusetts to initiate, change, or cancel credit entries to that account/s as indicated on this form. (For ACH debits consistent with the International ACH Transaction (IAT) rules, check one of the following.)

- I affirm that payments authorized hereunder are not to an account that is subject to being transferred to a foreign bank account.
- I affirm that payments authorized hereunder are to an account that is subject to being transferred to a foreign bank account.

This authority is to remain in full force and effect until the Office of Comptroller (CTR) has received written notification from either me or an authorized officer of the organization of the account's termination in such time and in such a manner as to afford CTR a reasonable opportunity to act upon it.

This authorization will remain in effect until it is canceled in writing or until an updated form changing information is sent to the department you currently do business with.

Signature of authorized representative \_\_\_\_\_  
(For signature requirements please see instructions.)

- Please contact your financial institution to arrange for the delivery of the CORE (Committee on Operating Rules for Information Exchange)-required Minimum CCD+ (Corporate Credit or Debit entry) data elements needed for reassociation of the payment and the Electronic Remittance Advice (ERA).
- The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.
- Instructions to complete the EFT Enrollment/Modification form can be found at [www.mass.gov/how-to/tips-for-completing-the-electronic-funds-transfer-eft-form](http://www.mass.gov/how-to/tips-for-completing-the-electronic-funds-transfer-eft-form). You may also confirm the status of your EFT enrollment by contacting MassHealth at (800) 841-2900, TDD/TTY: 711.
- The EFT user job aid that explains how providers can match the EFT payment to the remittance advice can be found at <https://massfinance.state.ma.us/VendorWeb/JobAidTraining/MassHealth.pdf>.
- The EFT Enrollment/Modification form can be completed manually or electronically. Electronic submissions must be printed, signed, faxed or mailed in the following ways.

Fax:  
(617) 988-8974

Mail:  
MassHealth Provider Enrollment and Credentialing  
PO Box 278  
Quincy, MA 02171-0278

[Print](#) [Clear](#)

This section is for Providers who are submitting a new EFT to change their EFT information after they are enrolled. It can be ignored if you are enrolling in MassHealth for the first time.

## CERTIFICATION

- The Provider should list their name at the beginning of the Certification
- Check off **one** of the boxes in the Certification section. Do NOT check off both boxes
- Include the signature of the person filling out the EFT

# Massachusetts Substitute W-9 Form (W-9)

# Overview of the W-9

*“Why do I have to fill out a W-9?”*

MassHealth requires Providers who will be paid directly for their claims to fill out a W-9. The W-9 will be submitted to the IRS so that they can confirm your Tax ID number for tax-filing purposes.

If the Provider will not be paid directly for their services to MassHealth patients at the service location listed on the Application, then you do NOT need to fill out a W-9.

# Overview of the W-9 – Page 1



Request for Taxpayer Identification Number and Certification		Completed form should be given to the requesting department or the department you are currently doing business with.
Name (as shown on your income tax return). Name is required on this line, do not leave this line blank.		
Business name/disregarded entity name, if different from above.		
Check the appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/ Estate <input type="checkbox"/> Other ►		
Legal Address: number, street, and apt. or suite no.	Remittance Address: if different from legal address number, street, apt. or suite no.	
City, state and ZIP code	City, state and ZIP code	
Phone:	Fax:	Email address:
<b>Part I Taxpayer Identification Number (TIN)</b> Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instruction on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2. Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.		
Vendors: Dunn and Bradstreet Universal Numbering System (DUNS)		
<b>Part II Certification</b> Under penalties of perjury, I certify that:		
1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am an U.S. person (including an U.S. resident alien). 4. I am currently a Commonwealth of Massachusetts state employee: (check one): No _____ Yes _____ If yes, in compliance with the State Ethics Commission requirements.		
Certification instructions: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply.		
Sign Here	Authorized Signature ►	
Date ►		
<b>Purpose of Form</b> A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or debt, or contributions you made to an IRA. Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the requester (the person who is requesting it (the requester) and, when applicable, to:		
1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued). 2. Certify you are not subject to backup withholding. If you are a foreign person, use the appropriate Form W-8. See Pub 515, Withholding Tax on Nonresident Aliens and Foreign Corporations.		
<b>What is backup withholding?</b> Persons making certain payments to you must withhold a designated percentage, currently 28% and pay the IRS of such payments under certain		
conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and banker exchange transactions, rents, royalties, nonemployee pay and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding. If you give the requester your correct TIN, make the proper certifications, and report all your payments to the IRS on your tax return, payments you receive will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:		
1. You do not furnish your TIN to the requester, or 2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or 3. The IRS tells the requester that you furnished an incorrect TIN, or 4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends only.		
<b>Penalties</b> <b>Failure to furnish TIN.</b> If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect. <b>Civil penalty for false information with respect to withholding.</b> If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty. <b>Criminal penalty for falsifying information.</b> Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment. <b>Misuse of TINs.</b> If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.		

## Provider Information:

- List the provider's legal name (should match what was included on the EFT)
- List their business' legal name
- Check off the appropriate box that describes the Provider (in this case the "Individual/Sole proprietor" box)
- List the residential Home address of the Provider on the left side of the page and, in the field below that, the city/state/zip
- On the right side of the page list the Remittance Address (if it is different from the residential Home Address)
- List the phone number, fax number, and email address associated with the Home Address

## PART 1

- Under the Social Security number heading, list the Provider's full SSN using the two little dashes to divide the SSN's three different sections (so 111-11-1111, like normal)

## PART 2

- Attest whether or not the Provider is currently a state employee of the Commonwealth of Massachusetts by checking off "Yes" or "No".
- The signature of the Provider who is being enrolled in MassHealth
- Include the signature date

# Overview of the W-9 – Page 2



## Specific Instructions

**Name.** If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC that is not a domestic entity) and is disregarded as an entity separate from its owner/owner, Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-9.

**Other entities.** Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

## Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see [How to get a TIN](#) below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see [Limited liability company \(LLC\)](#) above), and are owner(s) of an individual, enter your SSN or "pre-LLC" EIN, if desired. If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

**Note:** See the chart on this page for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3670) or from the IRS's Internet Web Site: [www.irs.gov](http://www.irs.gov).

If you do not have a TIN, write "Applied For" in the space before the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments.

The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note:** Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

## Part II - Certification

To establish to the paying agent that your TIN is correct or you are a U.S. person, or resident alien, sign Form W-9.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid by a mortgage, investment, or paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice in civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must deduct certain amounts from a corporation's currently 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see [Limited liability company \(LLC\)](#) above), and are owner(s) of an individual, enter your SSN or "pre-LLC" EIN, if desired. If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

**Note:** See the chart on this page for further clarification of name and TIN combinations.

## What Name and Number to Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup> The minor <sup>2</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The grantor-trustee <sup>3</sup>
4. a. The usual revocable savings trust (grantor is alive) b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship	The owner <sup>3</sup> Legal entity <sup>4</sup>
7. A valid trust, estate, or pension trust	The corporation
8. Corporate	The organization
9. Association, club, religious, charitable, educational, or other tax-exempt organization	
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

**Note:** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

**If you have questions on completing this form, please contact the Office of the State Comptroller. (617) 973-2468.**

**Upon completion of this form, please send it to the Commonwealth of Massachusetts Department you are doing business with.**

There is nothing to fill out on the second page of the W-9. Hooray!

# Resources

# MassHealth Resources

- MassHealth Website ([www.mass.gov/masshealth](http://www.mass.gov/masshealth))
  - Provider Publications: Is a library of resources for providers. You can find regulations specific to all provider types such as administrative and billing instructions, and service codes. <https://www.mass.gov/lists/provider-publications>
  - All Provider Bulletins: issued by MassHealth as needed to communicate procedures, reminders and other information to MassHealth Providers. <http://www.mass.gov/eohhs/gov/laws-regs/masshealth/provider-library/provider-bulletins/>
  - Provider Manuals: Provider specific information regarding MassHealth regulations. <https://www.mass.gov/lists/masshealth-provider-manuals>
  - Vendor List: Lists the approved vendors and clearing houses approved to submit electronic HIPAA-compliant transactions <https://www.mass.gov/service-details/vendor-list>
  - Direct Data Entry (DDE) Job Aids: Information that will help you with DDE submissions. <https://www.mass.gov/service-details/masshealth-claims-information-for-direct-data-entry-dde>
- Provider Online Service Center (POSC) ([www.mass.gov/masshealth/providerservicecenter](http://www.mass.gov/masshealth/providerservicecenter))
  - One Point access for member eligibility requests, prior authorizations, PCC referrals, claim submission and status requests, provider information maintenance and administration of accounts. <https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/providerLanding/providerLanding.jsf>
  - POSC Job Aids are “guides” that correspond with specific functions of the MMIS and are available under the “Need Additional Information or Training” link. <https://www.mass.gov/service-details/job-aids-for-the-provider-online-service-center-posc>
  - MMIS Notices by function are available through the “Important. Please read MMIS messages – By Function” link. <https://www.mass.gov/masshealth-provider-remittance-advice-message-text>

# MassHealth Resources



- **MassHealth Customer Service:**  
<http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/customer-services/business-hours-voice-menu.html>
  - Call Customer support **1-800-841-2900**
    - Most questions can be resolved by the customer support team
  - Or e-mail us at [Provider@masshealthquestions](mailto:Provider@masshealthquestions).
    - If your question is not urgent or more complex you can e-mail your question along with any supporting claim numbers or documentation.
- **Sign up for E-mail Alerts**
  - [join-masshealth-provider-pubs@listserv.state.ma.us](mailto:join-masshealth-provider-pubs@listserv.state.ma.us)

## General Questions

- **Q:** how is the effective date determined for a Provider's Program Eligibility?
  - **A:** The Provider's Eligibility Effective Date is the day on which the Provider Enrollment Credentialing team can complete credentialing of the Provider's Enrollment and enter their information into the MassHealth database. This does mean that the Eligibility Effective Date could be several days after the PEC team receives the Enrollment.
- **Q:** Can we submit an enrollment via encrypted email?
  - **A:** No. MassHealth did previously accept Enrollment documents via email, but we no longer accept Enrollments this way out of concern for the security of the Personally Identifiable Information included on the Application and other forms.
- **Q:** Do you have to submit a brand-new Enrollment in order to add an active MassHealth provider who is already enrolled with a group to another facility address within that same group?
  - **A:** No. All you need to do is send in a letter of intent listing the PID/SL of the Provider and the PID/SL you would like us to link them to. You can also indicate a future date for the link to go into effect, if desired. Please note, however, that MassHealth never back-dates group links.
- **Q:** Is there a form we can submit to remove providers who leave a Group Practice?
  - **A:** There is not a specific form provided by MassHealth to disassociate a Provider from a Group Practice, but you can submit a letter of intent listing the PID/SL of the Provider and the PID/SL of the Group practice you would like us to disassociate them from. You can also indicate a future date for the disassociation to go into effect, if desired.
- **Q:** Is there a separate MassHealth Enrollment process for out of state Providers?
  - **A:** Providers whose practice address is within 50 miles (as the bird flies) of the MA state border are eligible to enroll in MassHealth using the same enrollment process used by in-state Providers.

## General Questions

- **Q:** I am a practitioner and the only one at my company/practice. Would you recommend I use the Individual or Group application? I'm currently pending an application and I think this is where I am stuck.
  - **A:** This depends on what you want to do. If you are enrolling in MassHealth and want to bill through your group (for example, you want the payouts sent to a bank account opened using your company's Tax ID number), then you should enroll your company as a Group Practice Organization. You should then enroll yourself using the Individual Application and have yourself linked to the group. If you do not want to bill through a group (i.e. you want the payouts sent to a bank account opened under your own SSN), then you should enroll as an Individual Practitioner practicing independently.
- **Q:** Do we have to be affiliated with a Group Practice to enroll as an Individual Practitioner practicing independently?
  - **A:** No, you can enroll as an Individual Practitioner practicing independently without needing to be linked to a Group Practice Organization. To do this, you must include a completed EFT, W-9, and bank letter/voided check along with the rest of your Enrollment.
- **Q:** Is there any way to check if an Individual Provider is enrolled in MassHealth?
  - **A:** Yes, you can check a Provider's enrollment status by accessing the provider Online Service Center's Provider Search Function. In order to use the Provider Search Function, you must be logged into the POSC. The Provider Search Option is in the left navigation menu. Results will return PROVIDER NAME, ADDRESS, NPI and "ACTIVE Y" or "No active MassHealth providers found". Note that you cannot use this feature to search for enrolled MCE Providers.
- **Q:** Can MassHealth welcome letters (which list the new Provider's PID/SL and effective date) be sent to the contact email instead of being mailed to the DBA address?
  - **A:** You can email [pec@maximus.com](mailto:pec@maximus.com) to request copies of the welcome letters and they will then be emailed to you. Be ready to supply the NPI or ATN of the Enrollment(s) in question so that our staff will know which letters to send you.

## General Questions

- **Q:** If a Provider did not revalidate and now must re-enroll, Is this considered a new enrollment or reactivation?
  - **A:** It would be a reactivation, AKA a “reinstatement”.
- **Q:** If a Provider is enrolled as Non-Billing with MassHealth, is that Provider also a Non-Billing provider through, for example, Tufts Public or Mass General Brigham’s Medicaid plan?
  - **A:** Enrollment with MassHealth, whether billing or non-billing, is only for MassHealth network plans (FFS, PCC plan, Primary Care ACO plan). Enrollment with MassHealth does not provide enrollment into an MCO plan or an Accountable Partnership plan. For example, Tufts is not a MassHealth network plan, so enrollment with MassHealth will have nothing to do with Tufts. The provider would have to enroll with Tufts to utilize their network. Please refer to the list of plans here to identify the appropriate plan type: <https://www.mass.gov/guides/payment-care-delivery-innovation-pcdi-for-providers>

## Application

- **Q:** What is the process for updating the service location info entered in Section 2.3?
  - **A:** Send in a letter of intent listing the PID/SL of the Provider and the new service location address. The service location can not be a P.O. Box. If the Provider is not an Independent Practitioner, then the new address must also belong to a Group Practice Organization that the Provider is linked to.

## FRDF

- **Q:** Can a group practice be listed as an agent in Section 3?
  - **A:** Yes.

# Questions?