MassHealth Provider Enrollment Overview – Individual Fee-For-Service Providers

Executive Office of Health & Human Services

Agenda

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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/eohhs-regulations.

Enrollment Documents

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

- Provider Enrollment Data Collection Form and Registration Instructions ("DCF", February 2024 revision)
- Federally Required Disclosures form for Individual Practitioners ("FRDF", November 2023 revision)
- MassHealth Provider Contract for Individuals (November 2023 revision)

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

- Electronic Funds Transfer (EFT) Enrollment/Modification Form ("EFT", March 2023 edition)
- Electronic Remittance Advice Enrollment/Modification Form ("ERA-1", March 2023 edition)
- Massachusetts Substitute W-9 Form ("MA W-9", March 2020 revision **OR** April 2022 revision)
- Trading Partner Agreement (TPA, November 2023 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.

POSC Enrollment

The Provider Online Service Center (POSC) is one method for submitting provider enrollments and for maintaining file integrity

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

The POSC Application is a stand-in for the Provider Application itself; Any supplementary Enrollment documents (FRDF, EFT, Etc.) should be scanned and attached to the POSC Application as PDFs

Tips for Completing Enrollment

- **MassHealth 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.

- Make sure all sections of the enrollment forms are complete, especially any sections addressing “Disclosures”.

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 but the address listed is an MA address. 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 but no indication of license pending and/or anticipated license issue date. 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

How to Submit An Enrollment

"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

Waiting For Information/Outreach

If MassHealth needs to clarify anything about the Enrollment, then the MassHealth Outreach team and PEC will reach out to the person listed in the contact information on the Provider Application. You have 60 Days from the day PEC receives the Enrollment forms to rectify any errors on them.

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 is mailed to the DBA address indicated on the application
2. If no response is received within 5 days, the Outreach team 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 Outreach 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.

If the Provider Enrollment Credentialing team does not get all the information it needs to complete credentialing all your forms by the end of day 60, then your Enrollment will be DENIED

Tip: If you want to mail in your enrollment (as opposed to faxing it), then make sure you keep a copy of the forms you submitted so that if you must resubmit the forms, you don't have to do everything all over again.

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:

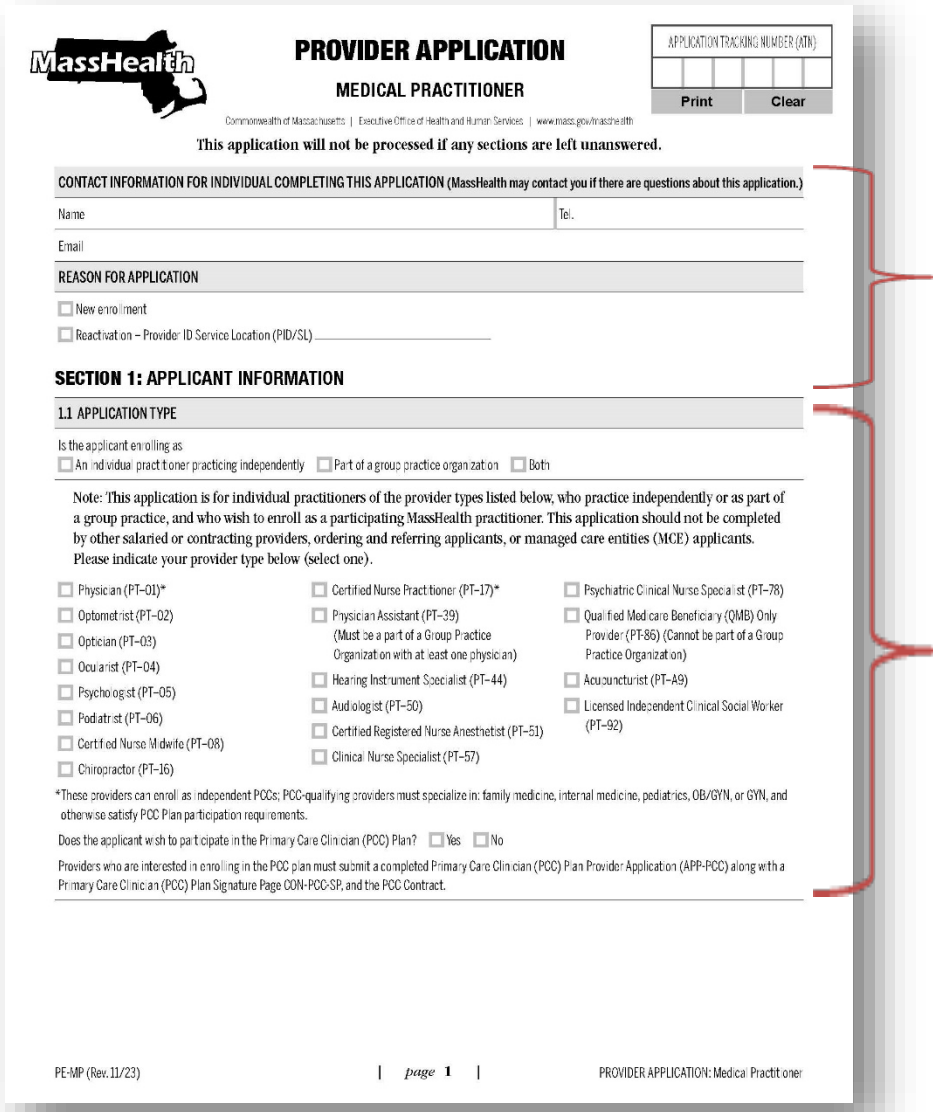
- **The Provider Application Form**
- **The Provider Enrollment Data Collection Form**
- **The Federally Required Disclosures Form (FRDF)**
- **The Electronic Funds Transfer Form (EFT)**
- **Massachusetts Substitute W-9 Form (W-9)**

We will not be going over the Contract or Trading Partner Agreement in this presentation. If you do have issues with any of these forms, please contact **MassHealth Customer Service**:

- Email: Provider@masshealthquestions.com
- Phone: (800) 841-2900; TTD/TTY: 711

Provider Application Form

Overview of the App – Page 1



MassHealth

PROVIDER APPLICATION

MEDICAL PRACTITIONER

APPLICATION TRACKING NUMBER (ATN)

Print | Clear

Commonwealth of Massachusetts | Executive Office of Health and Human Services | 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 (PID/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)*
☐ Optometrist (PT–02)
☐ Optician (PT–03)
☐ Ocularist (PT–04)
☐ Psychologist (PT–05)
☐ Podiatrist (PT–06)
☐ Certified Nurse Midwife (PT–08)
☐ Chiropractor (PT–16)
☐ Certified Nurse Practitioner (PT–17)*
☐ Physician Assistant (PT–39) (Must be a part of a Group Practice Organization with at least one physician)
☐ Hearing Instrument Specialist (PT–44)
☐ Audiologist (PT–50)
☐ Certified Registered Nurse Anesthetist (PT–51)
☐ Clinical Nurse Specialist (PT–57)
☐ Psychiatric Clinical Nurse Specialist (PT–78)
☐ Qualified Medicare Beneficiary (QMB) Only Provider (PT-86) (Cannot be part of a Group Practice Organization)
☐ Acupuncturist (PT–A9)
☐ Licensed Independent Clinical Social Worker (PT–92)

*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.

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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.

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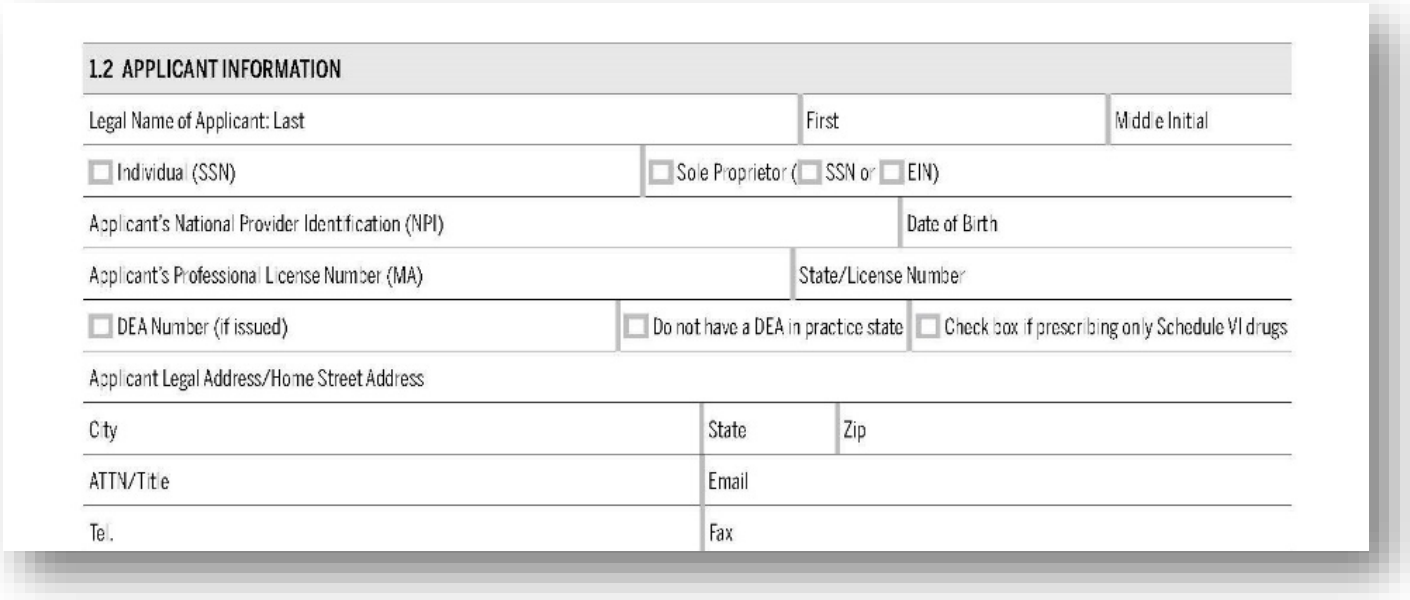


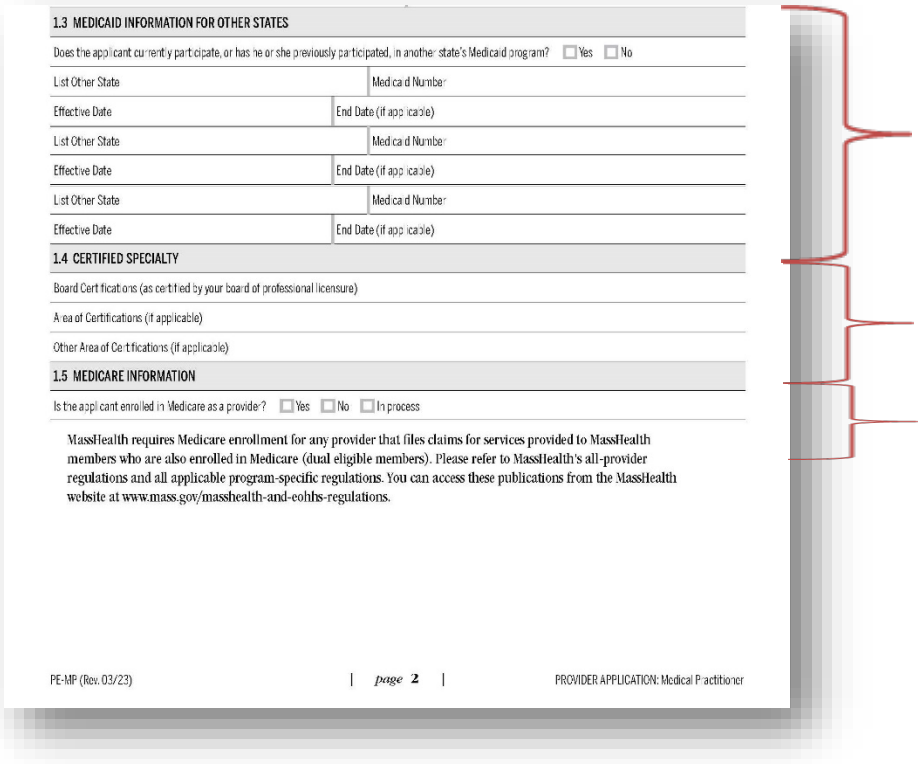
1.2 APPLICANT INFORMATION		
Legal Name of Applicant: Last	First	Middle Initial
☐ Individual (SSN)	☐ Sole Proprietor (☐ SSN or ☐ EIN)	
Applicant's National Provider Identification (NPI)	Date of Birth	
Applicant's Professional License Number (MA)	State/License Number	
☐ DEA Number (if issued)	☐ Do not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

Section 1.2: Applicant Information

- 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? ☐ Yes ☐ 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? ☐ Yes ☐ No ☐ 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.

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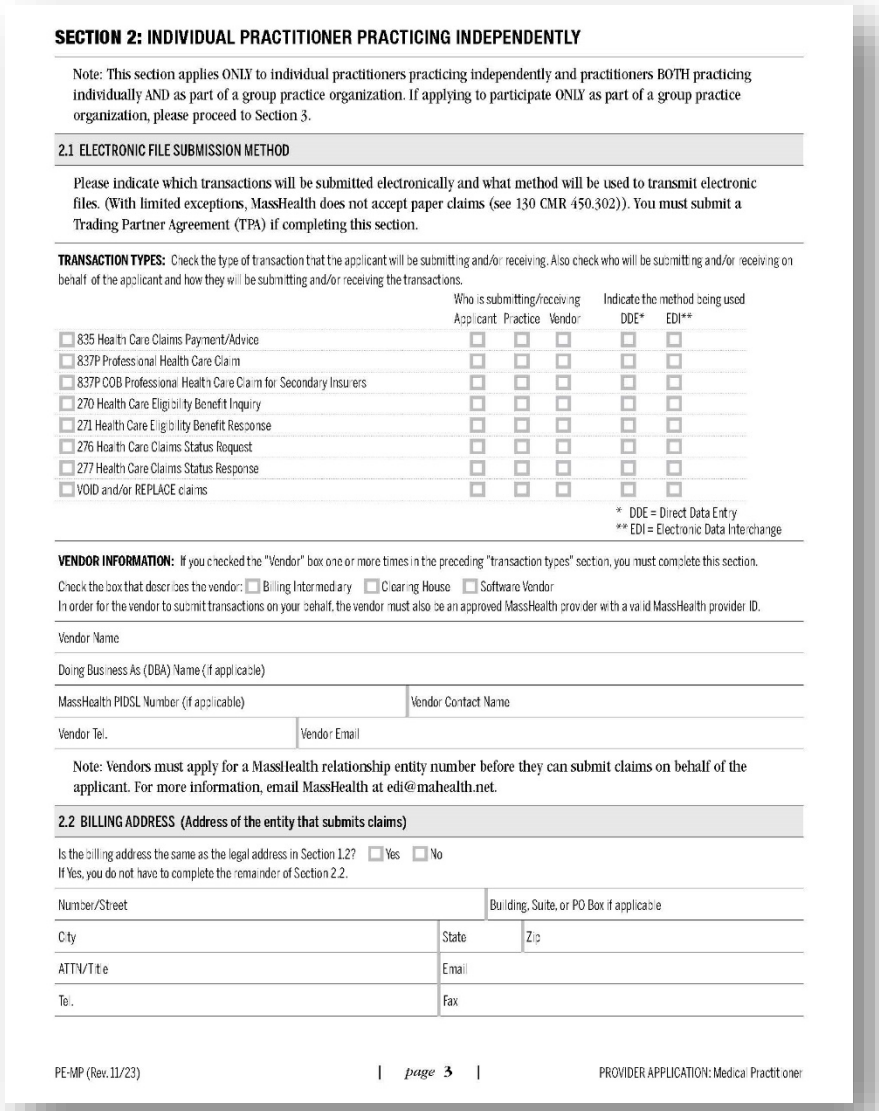
Section 1.3 Medicaid Information For Other States

- 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.
- Certain Provider types, such as APRNs and LICSWs, will need an active Medicare number to enroll

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.

	Who is submitting/receiving			Indicate the method being used	
	Applicant	Practice	Vendor	DDE*	EDI**
835 Health Care Claims Payment/Advice	☐	☐	☐	☐	☐
837P Professional Health Care Claim	☐	☐	☐	☐	☐
837P COB Professional Health Care Claim for Secondary Insurers	☐	☐	☐	☐	☐
270 Health Care Eligibility Benefit Inquiry	☐	☐	☐	☐	☐
271 Health Care Eligibility Benefit Response	☐	☐	☐	☐	☐
276 Health Care Claims Status Request	☐	☐	☐	☐	☐
277 Health Care Claims Status Response	☐	☐	☐	☐	☐
VOID and/or REPLACE claims	☐	☐	☐	☐	☐

* 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.

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	

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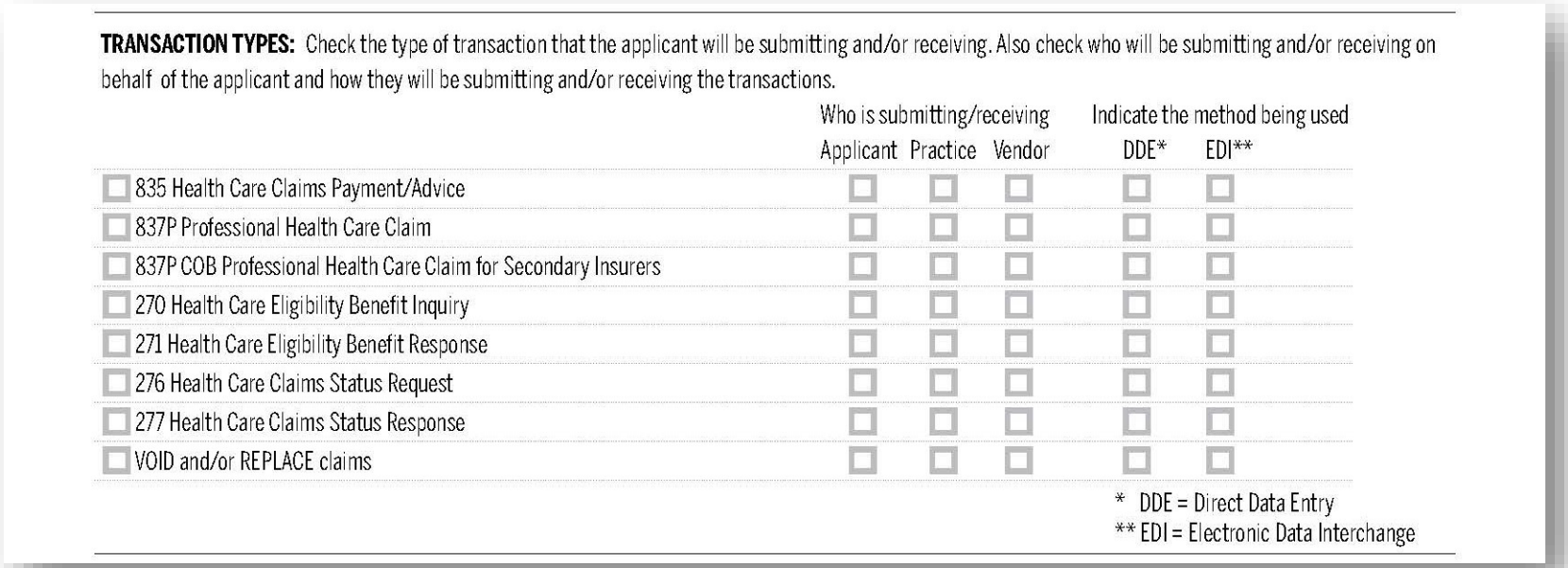
Section 2 applies ONLY to individual Providers practicing independently and to Providers practicing BOTH individually AND as part of a group practice.

If you are going to carry out a particular type of transaction with MassHealth (like submitting a health care claim), then you need to indicate if that transaction will be submitted by the Provider, a practice that the Provider is linked to, or by a 3rd party service like a vendor.

Overview of the App – Page 3 (cont.)



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.

	Who is submitting/receiving			Indicate the method being used	
	Applicant	Practice	Vendor	DDE*	EDI**
☐ 835 Health Care Claims Payment/Advice	☐	☐	☐	☐	☐
☐ 837P Professional Health Care Claim	☐	☐	☐	☐	☐
☐ 837P COB Professional Health Care Claim for Secondary Insurers	☐	☐	☐	☐	☐
☐ 270 Health Care Eligibility Benefit Inquiry	☐	☐	☐	☐	☐
☐ 271 Health Care Eligibility Benefit Response	☐	☐	☐	☐	☐
☐ 276 Health Care Claims Status Request	☐	☐	☐	☐	☐
☐ 277 Health Care Claims Status Response	☐	☐	☐	☐	☐
☐ VOID and/or REPLACE claims	☐	☐	☐	☐	☐

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

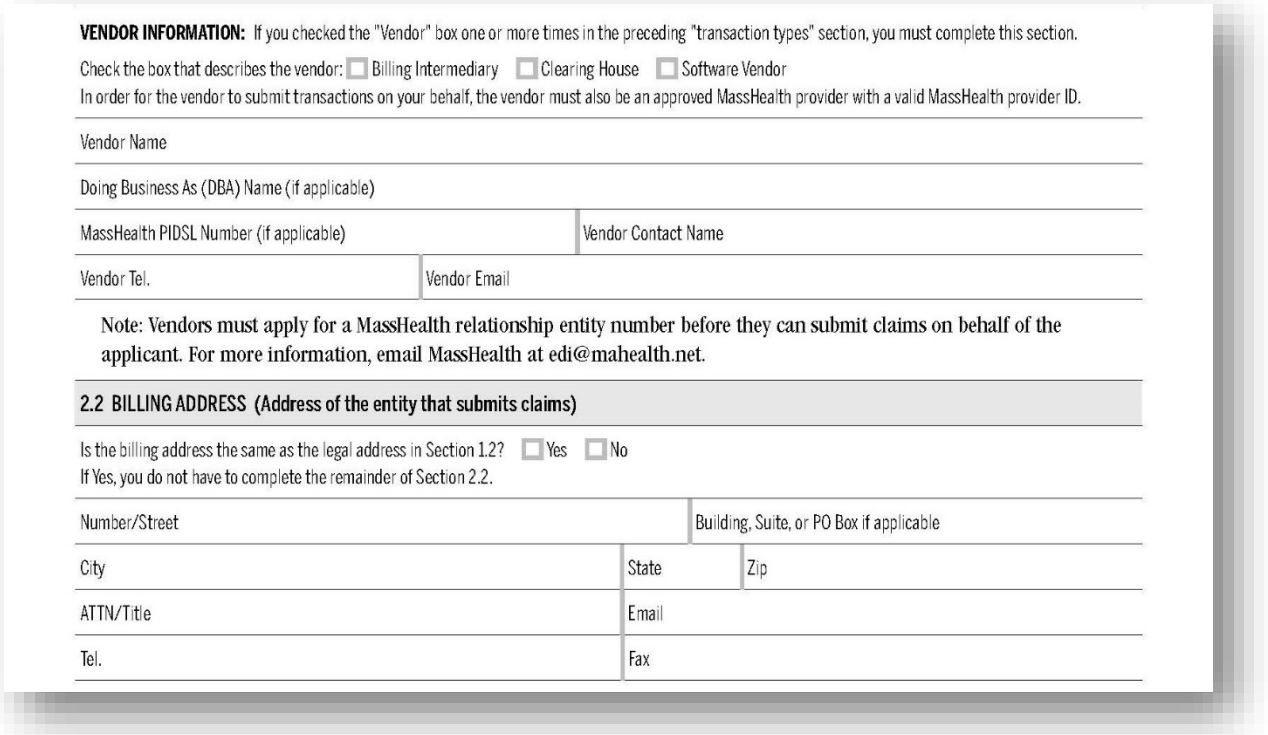
Transactions

- 835 – electronic Remittance Advice
- 837 – claim submission file
- 837 COB – claim submission file where MassHealth is not the primary payer
- 270 – member eligibility verification request
- 271 – member eligibility verification data (you need to submit a 270 to get the 271)
- 276 – claim status request
- 277 - claims status response (to the 276)

- **Submission Method**
- DDE - submitting one claim at a time
- EDI - submitting claims in batches

(All providers get DDE access by default, but if they plan to use EDI then we need to make sure their vendor is tested and approved and that everything captured correctly)

Overview of the App – Page 3 (cont.)



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.

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	

Vendor Information

If you answer "Vendor" for any of the transaction types, then list the full information for the vendor here, including the Vendor's MassHealth PID/SL (this does mean that any vendor you list here must already be enrolled with MassHealth)

2.2 Billing Address

- If the Provider's billing address is different than that of their Legal address, then list the billing address here.
- If the billing address and legal address are the same, then check off the box labeled "No"

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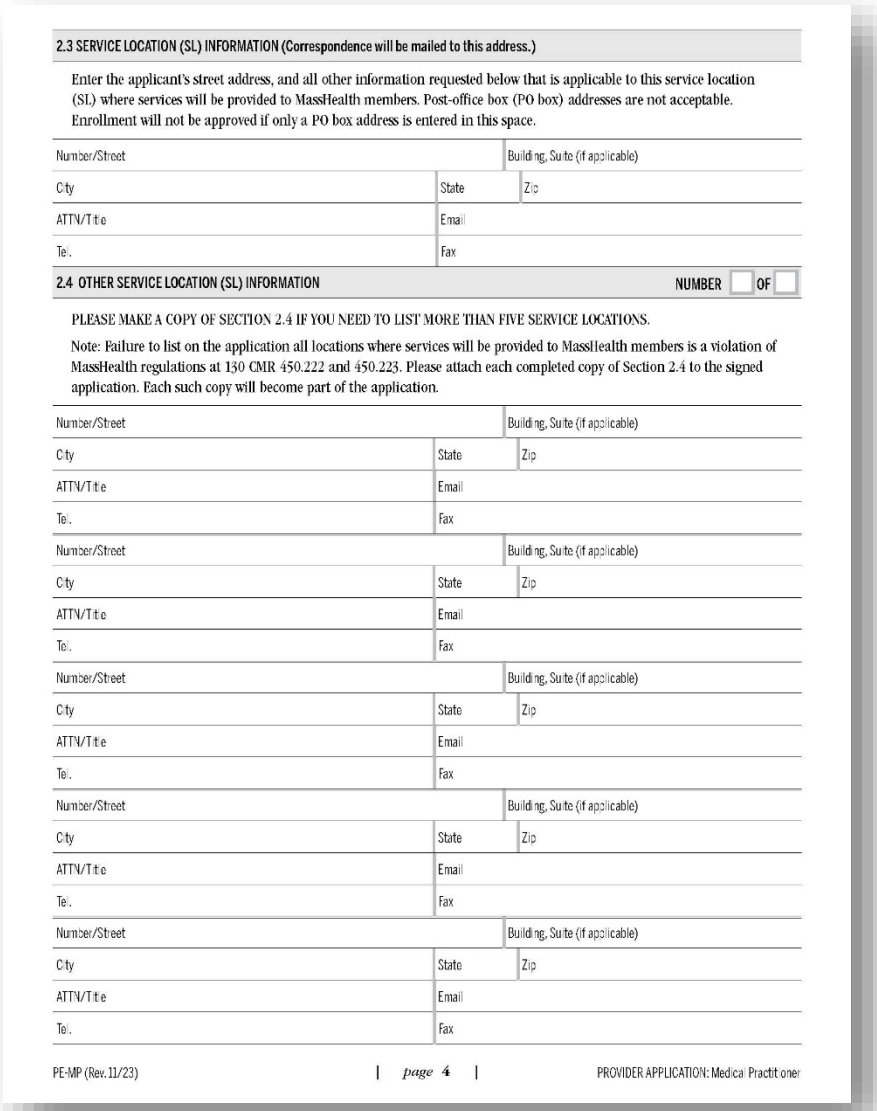

2.3 SERVICE LOCATION (SL) INFORMATION (Correspondence will be mailed to this address.)

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	

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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.

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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

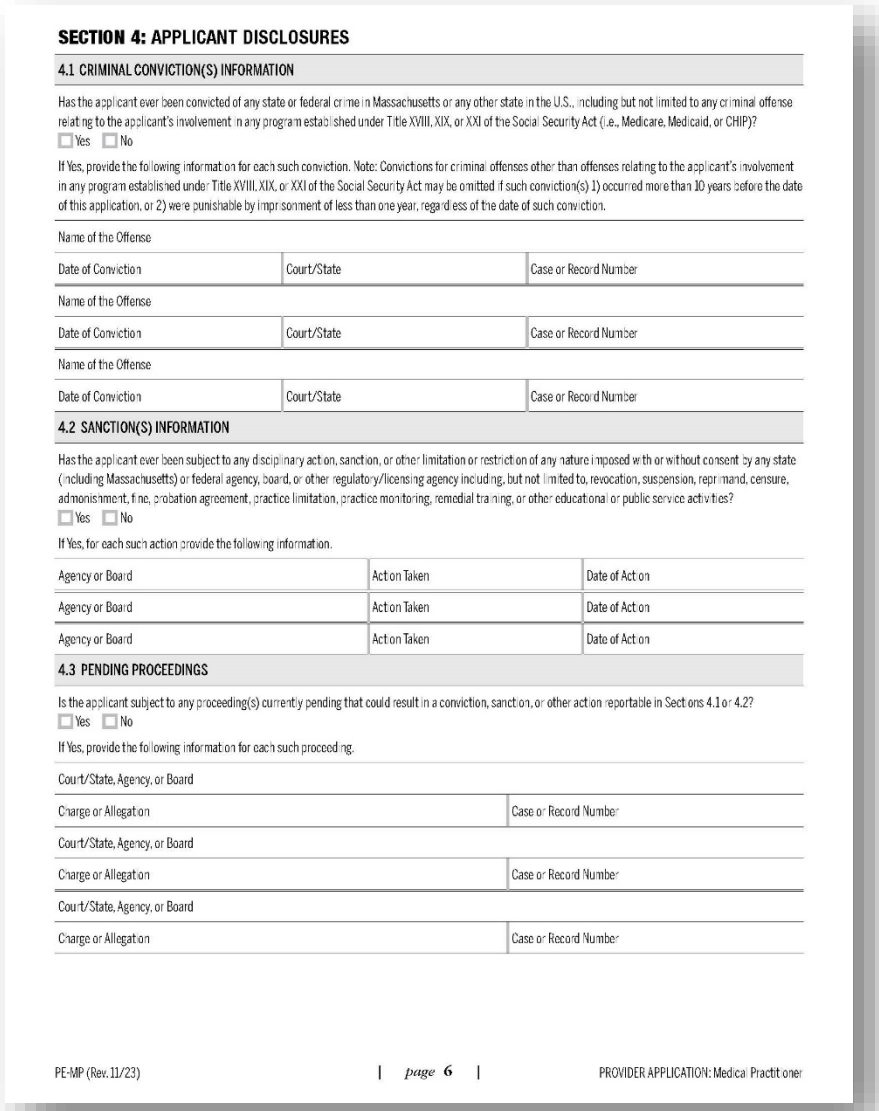
Group Practice Organization Address (number/street)

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

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
Agency or Board	Action Taken	Date of Action
Agency or Board	Action Taken	Date of Action

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	
Charge or Allegation	Case or Record Number
Court/State, Agency, or Board	
Charge or Allegation	Case or Record Number
Court/State, Agency, or Board	
Charge or Allegation	Case or Record Number

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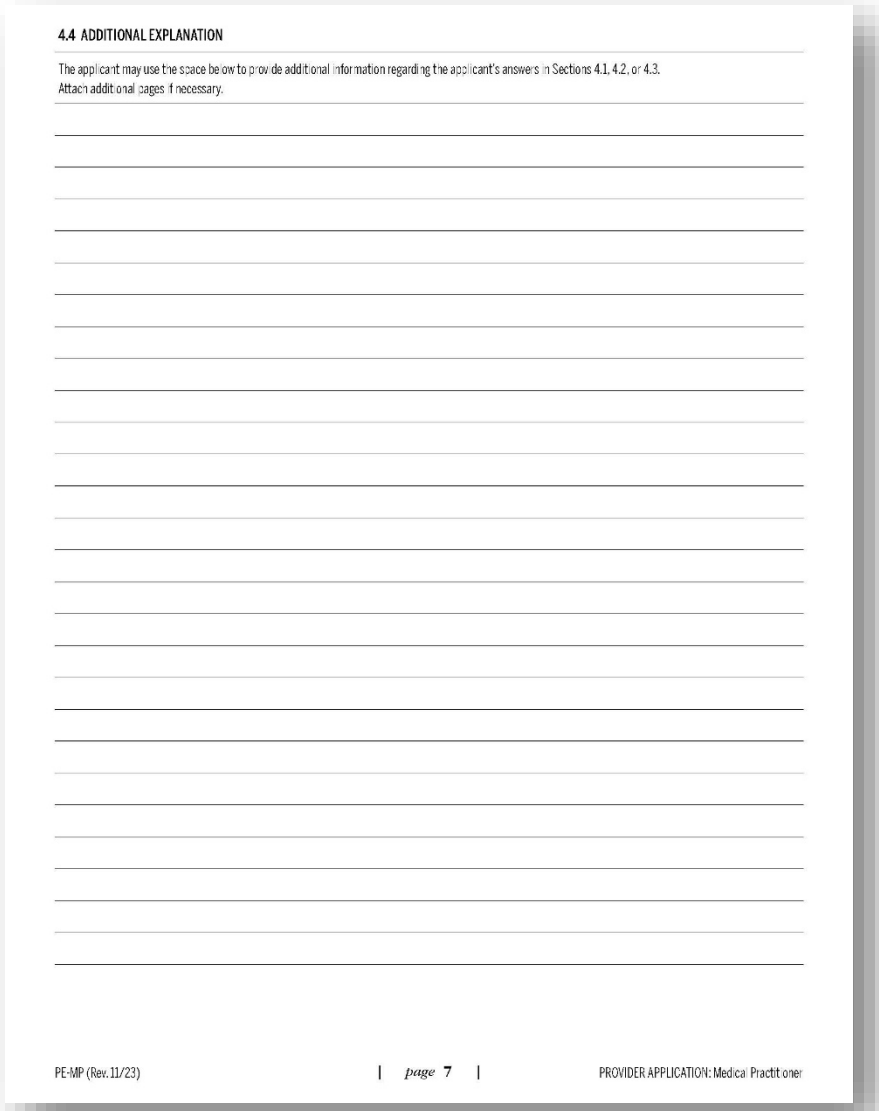
Disclose any Criminal Convictions, Sanctions, or Pending Proceedings involving the Provider in **Section 4**.

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

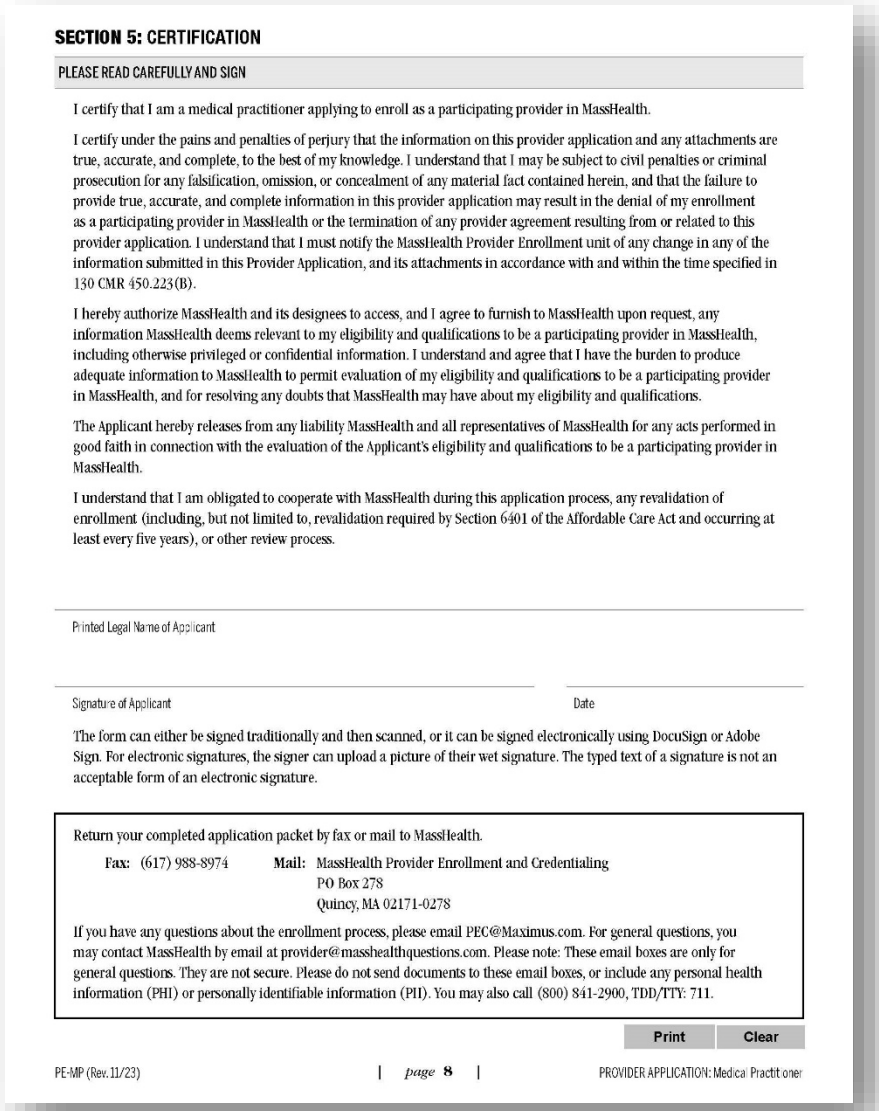
The applicant may use the space below to provide additional information regarding the applicant's answers in Sections 4.1, 4.2, or 4.3. Attach additional pages if necessary.

PE-MP (Rev. 11/23) | page 7 | PROVIDER APPLICATION: Medical Practitioner

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

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.

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

PE-MP (Rev. 11/23) | page 8 | PROVIDER APPLICATION: Medical Practitioner

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

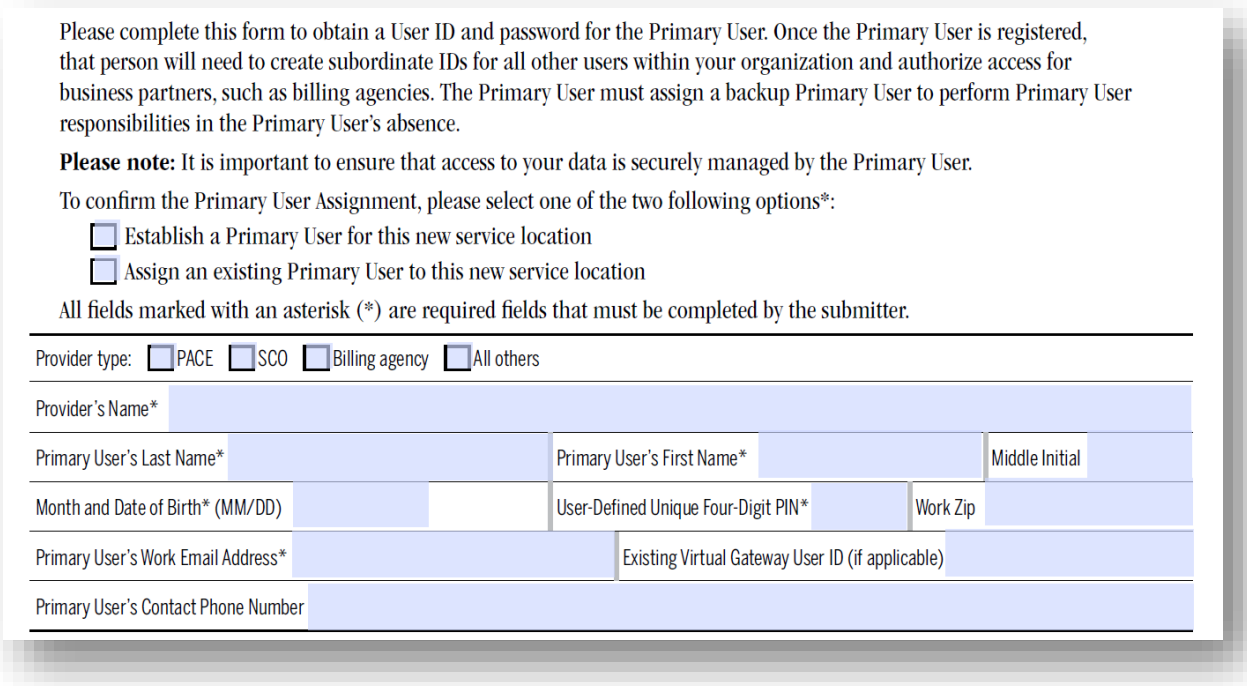
"Why do I have to fill out a Data Collection Form?"

MassHealth requires Providers to designate an individual who can access the Provider Online Service Center (POSC) on the Provider's behalf, known as the Primary User and a Backup Primary User. In the case of an individual Provider, these individuals might sometimes be someone other than the Provider. The DCF from collects info on who a Provider's Primary User will be.

The Primary User within a Provider's PID/SL is the person responsible for managing access to the Provider's information on the POSC (as described in All Provider Bulletin 377 and the Primary User Policy).

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
- The Primary User must pick their own 4-digit PIN number. The Primary User should SAVE their 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

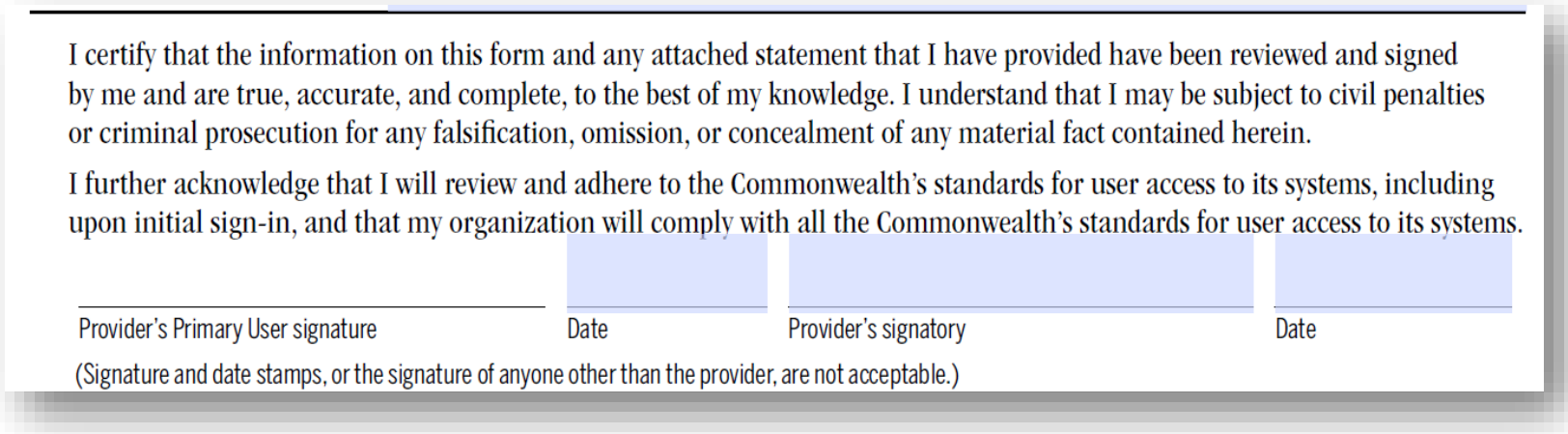
Month and Date of Birth* (MM/DD) | User-Defined Unique Four-Digit PIN* | Work Zip

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)

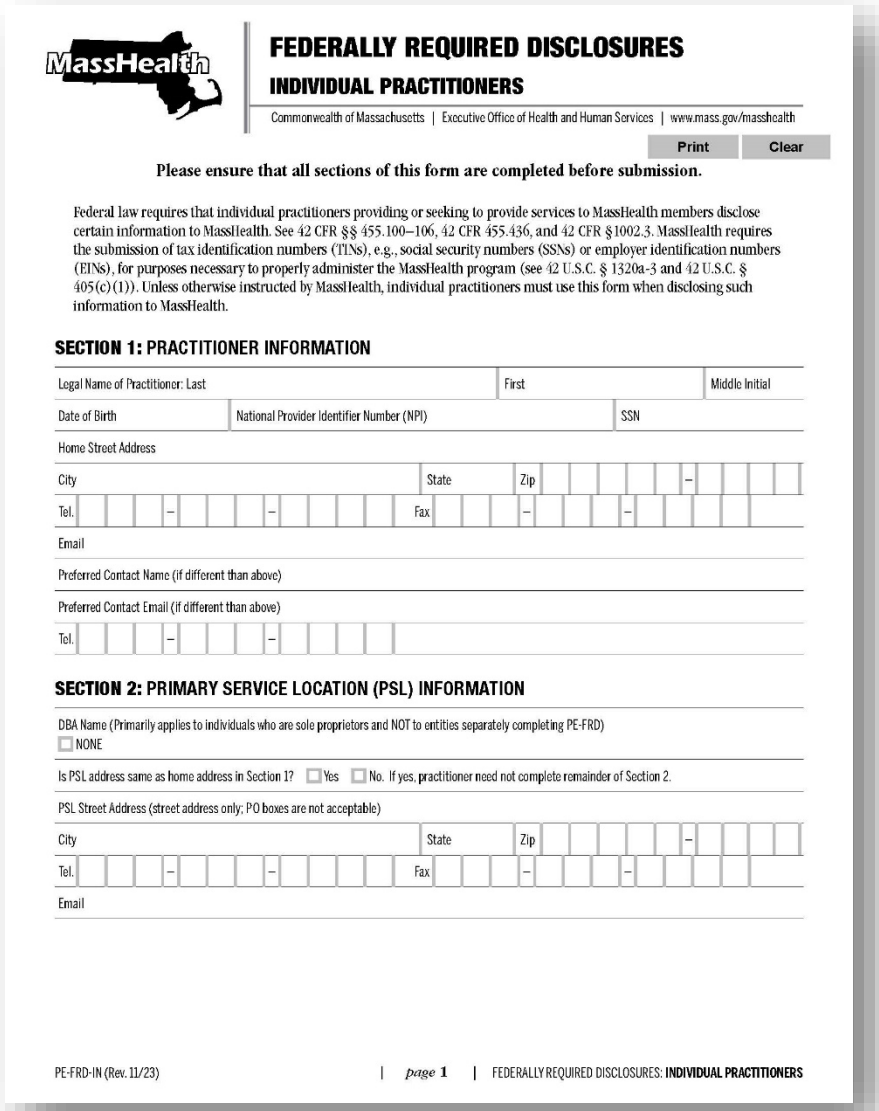
Overview of the FRDF

- 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



MassHealth

FEDERALLY REQUIRED DISCLOSURES

INDIVIDUAL PRACTITIONERS

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

Print Clear

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) | SSN

Home Street Address

City | State | Zip

Tel. | Fax

Email

Preferred Contact Name (if different than above)

Preferred Contact Email (if different than above)

Tel.

SECTION 2: PRIMARY SERVICE LOCATION (PSL) INFORMATION

DBA Name (Primarily applies to individuals who are sole proprietors and NOT to entities separately completing PE-FRD)
☐ NONE

Is PSL address same as home address in Section 1? ☐ Yes ☐ No. If yes, practitioner need not complete remainder of Section 2.

PSL Street Address (street address only; PO boxes are not acceptable)

City | State | Zip

Tel. | Fax

Email

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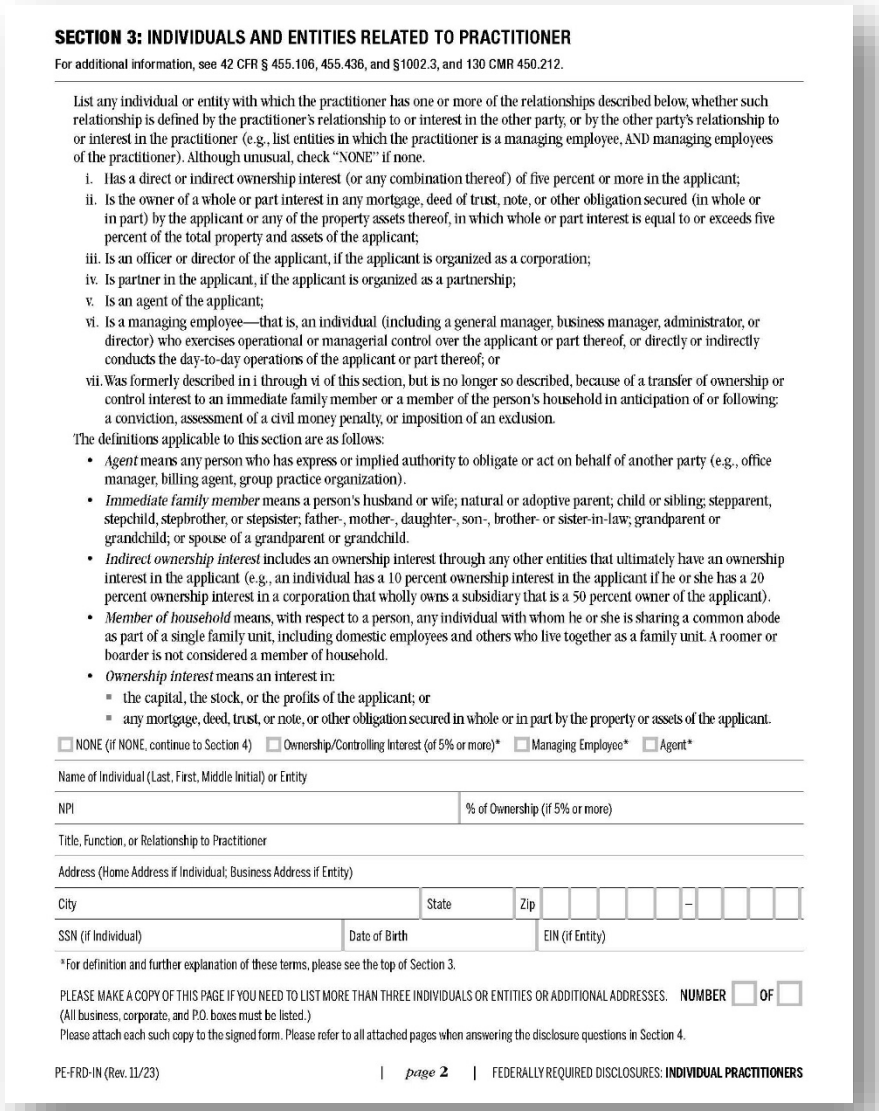
- Fill out **Section 1** with the individual Provider's:
  - Full legal name (L/F/M)
  - DOB
  - NPI
  - Full SSN
  - Residential Home Address (PO Boxes are NOT acceptable)
  - The provider's email
  - Contact person's name and email

- **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)

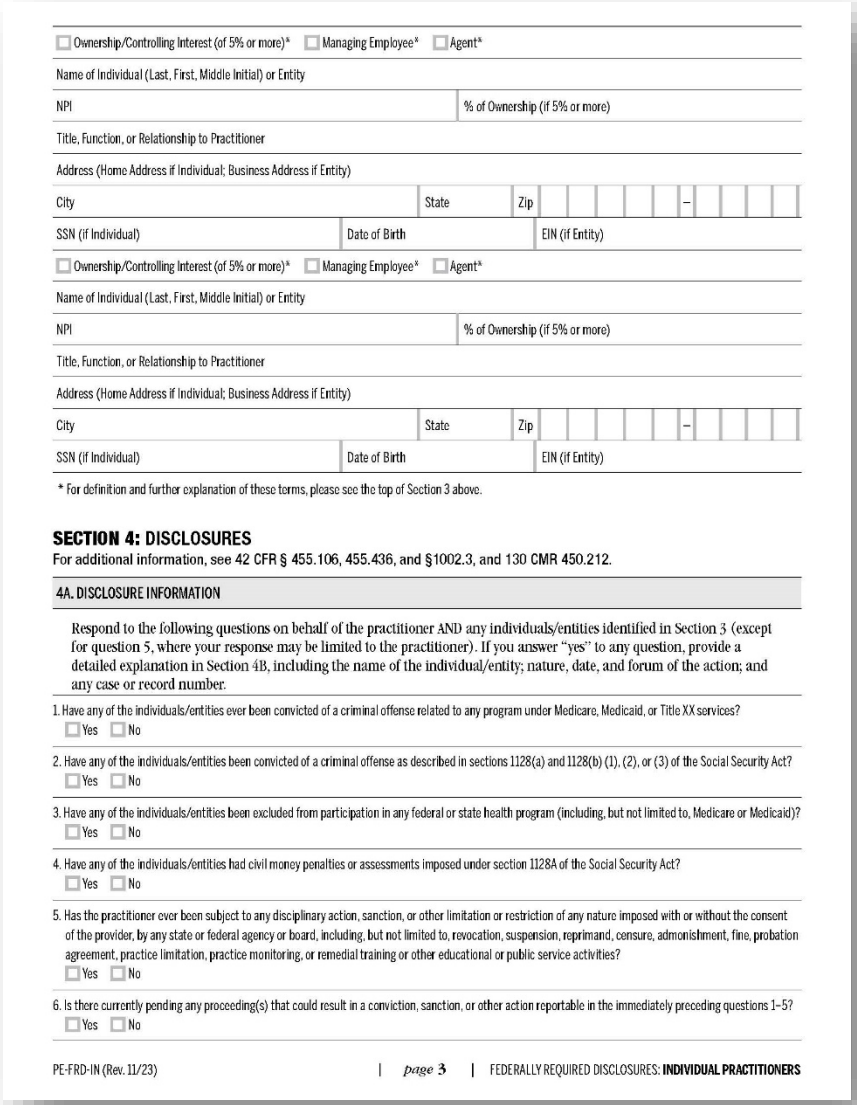
*For definition and further explanation of these terms, please see the top of Section 3.

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.

PE-FRD-IN (Rev. 11/23) | *page 2* | FEDERALLY REQUIRED DISCLOSURES: **INDIVIDUAL PRACTITIONERS**

- You must disclose any business relationships described in **Section 3** at the bottom of page 2
- If you have a relationship 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)
- In the case of FFS Providers linking to a group practice, it is required that the group practice be listed as an agent
- Do NOT leave Section 3 blank. If there are no relationships to disclose, check the box labeled "NONE"

Overview of the FRDF – Page 3



☐ 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)

☐ 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 above.

SECTION 4: DISCLOSURES

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

4A. DISCLOSURE INFORMATION

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?
☐ Yes ☐ 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?
☐ Yes ☐ 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)?
☐ Yes ☐ No

4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
☐ Yes ☐ No

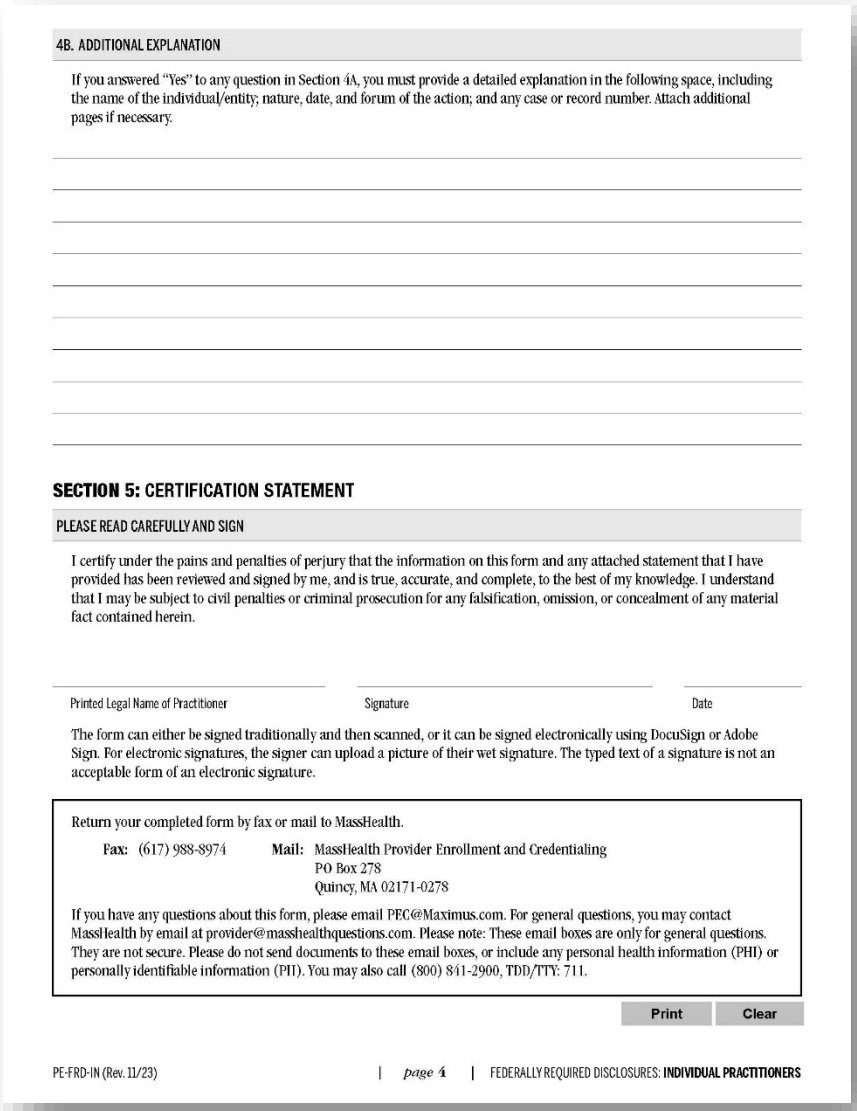
5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?
☐ Yes ☐ 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?
☐ Yes ☐ No

PE-FRD-IN (Rev. 11/23) | *page 3* | FEDERALLY REQUIRED DISCLOSURES: **INDIVIDUAL PRACTITIONERS**

- 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



4B. ADDITIONAL EXPLANATION

If you answered "Yes" to any question in Section 4A, you must provide a detailed explanation in the following space, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 5: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is 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.

Printed Legal Name of Practitioner | Signature | Date

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.

Return your completed form 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 this form, 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

PE-FRD-IN (Rev. 11/23) | *page 4* | FEDERALLY REQUIRED DISCLOSURES: **INDIVIDUAL PRACTITIONERS**

- 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)

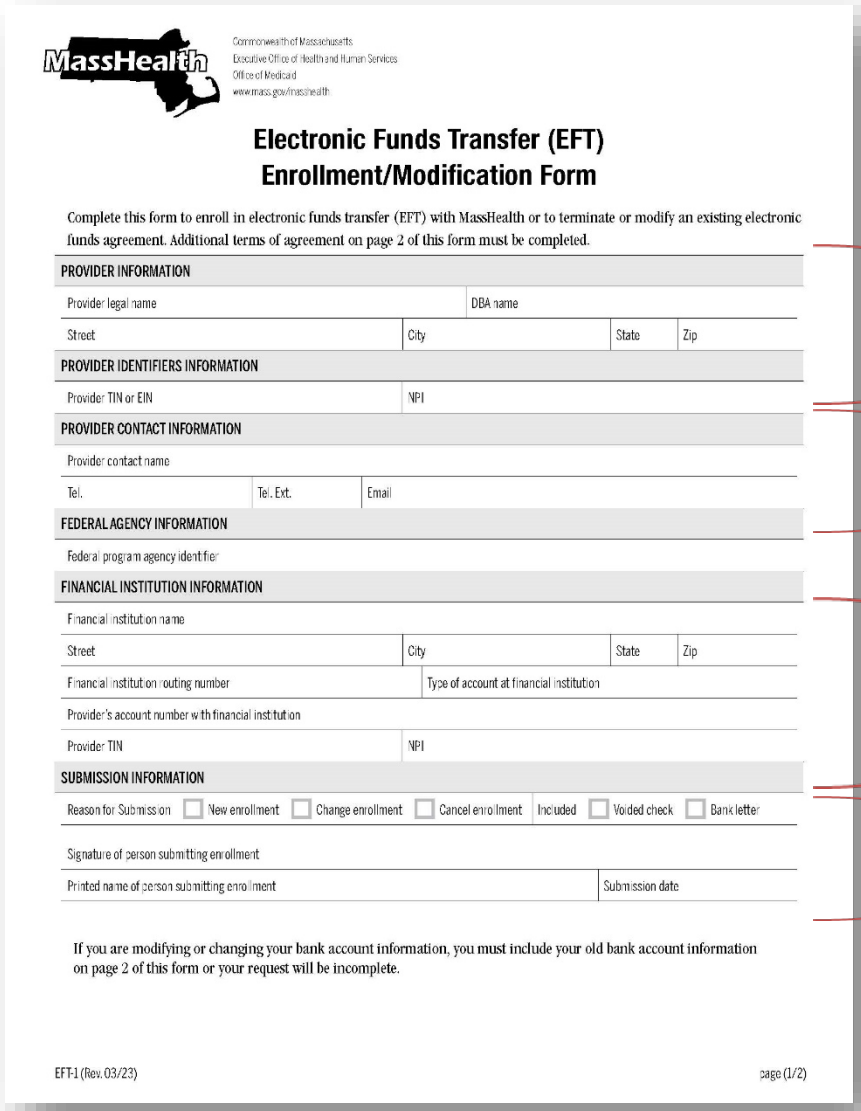
Overview of the EFT

"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, then you do NOT need to fill out an EFT.

Overview of the EFT – Page 1



MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
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 with financial institution			
Provider TIN	NPI		

SUBMISSION INFORMATION

Reason for Submission ☐ New enrollment ☐ Change enrollment ☐ Cancel enrollment Included ☐ Voided check ☐ 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.

EFT-1 (Rev. 03/23) page (1/2)

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

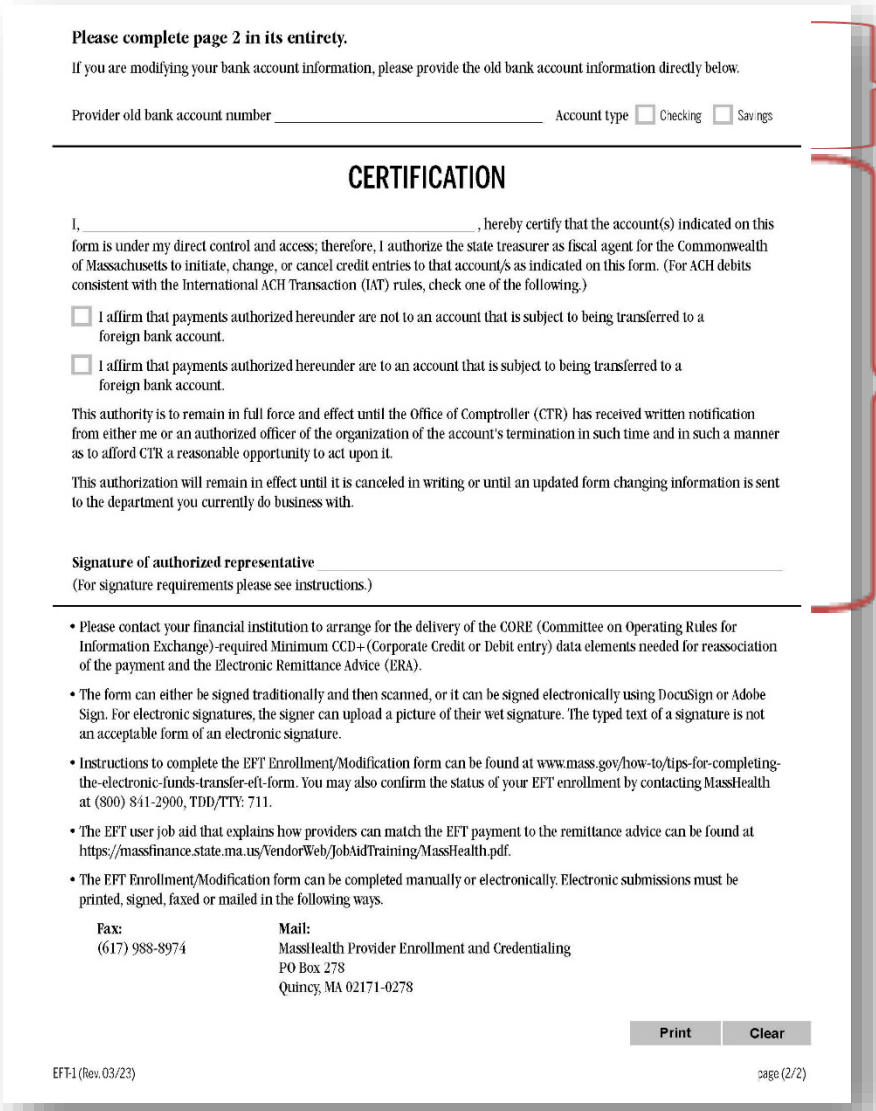
Financial Institution Information:

- 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. 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

EFT-1 (Rev. 03/23) page (2/2)

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)

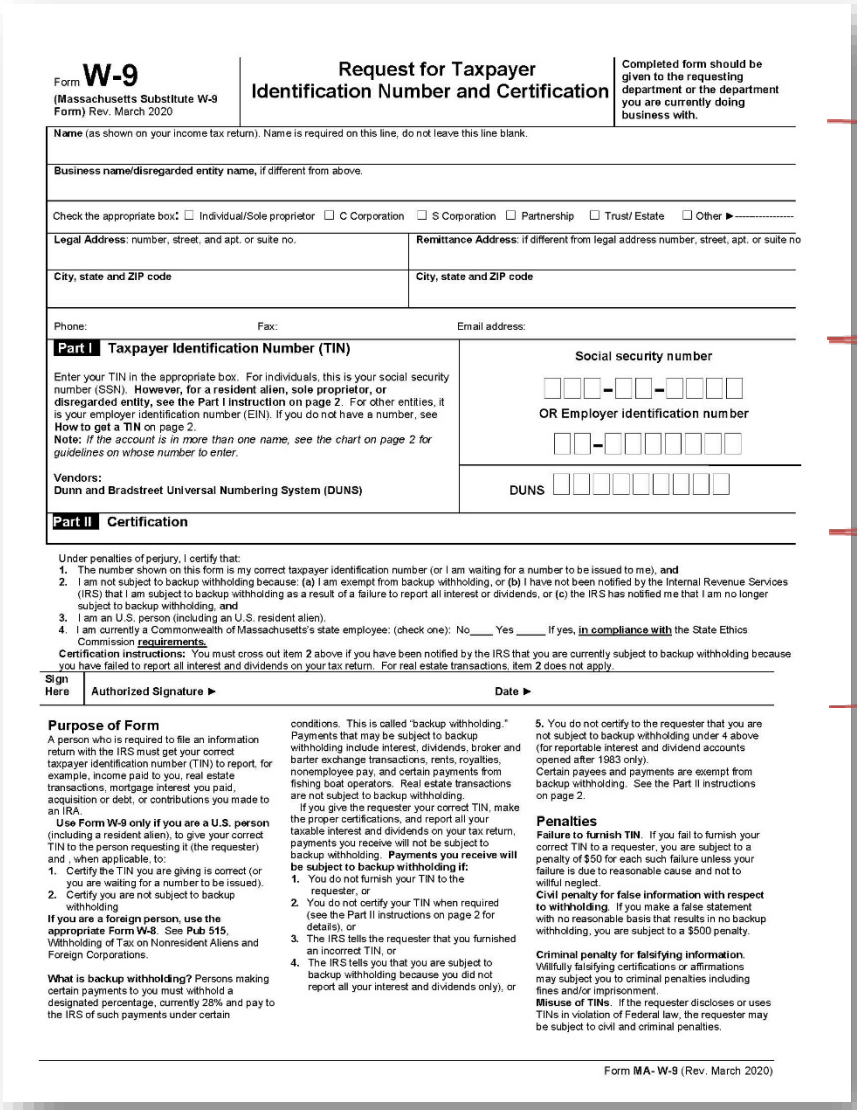
Overview of the MA W-9

"Why do I have to fill out an MA W-9?"

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

If the Provider will not be paid directly for their services, then you do NOT need to fill out a W-9.

Overview of the MA W-9 – Page 1



Form **W-9**
(Massachusetts Substitute W-9 Form) Rev. March 2020

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: ☐ Individual/Sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/ Estate ☐ 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:

Part I Taxpayer Identification Number (TIN)

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.*

Social security number
☐☐☐-☐☐-☐☐☐☐
OR Employer identification number
☐☐-☐☐☐☐☐☐☐

Vendors:
Dunn and Bradstreet Universal Numbering System (DUNS)

DUNS ☐☐☐☐☐☐☐☐☐

Part II Certification

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 Services (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's 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 ►**

Purpose of Form
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 person 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 of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding? Persons making certain payments to you must withhold a designated percentage, currently 28% and pay to 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 barter 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 taxable interest and dividends 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), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions on page 2.

Penalties
Failure to furnish TIN. 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.
Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.
Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

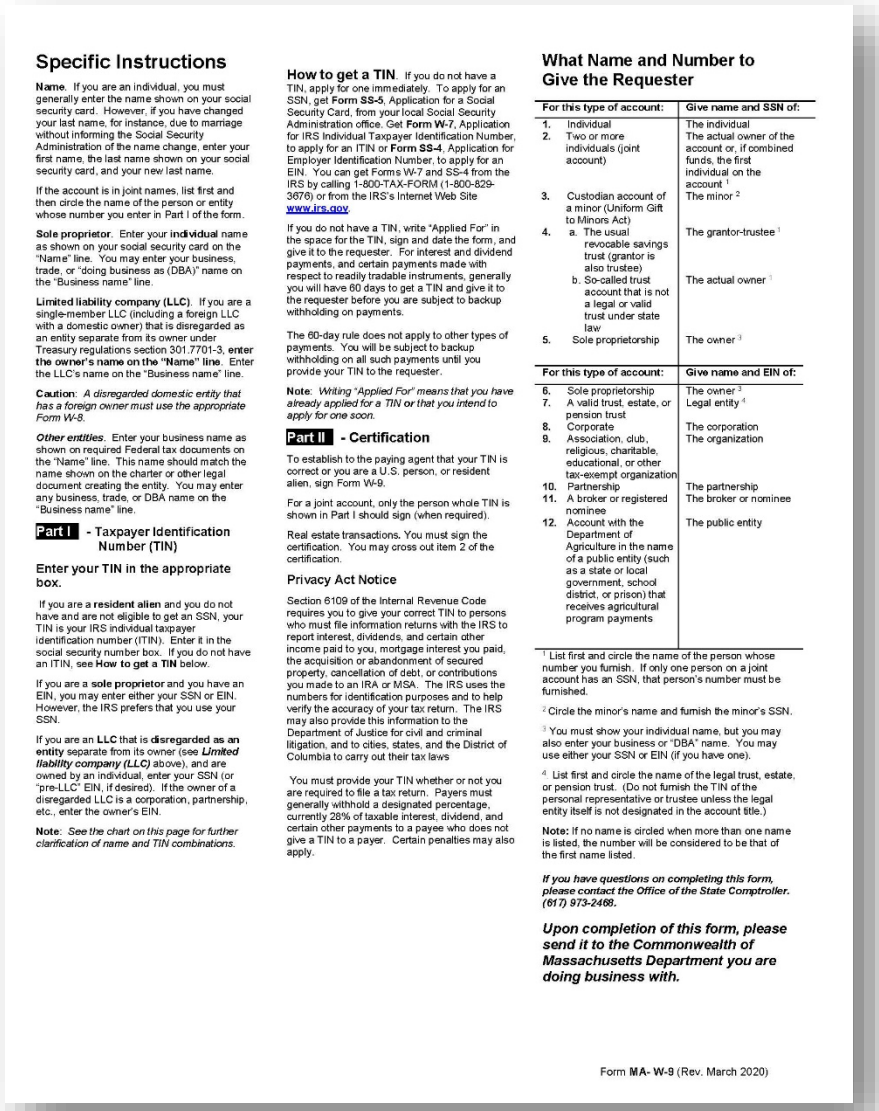
Form **MA- W-9** (Rev. March 2020)

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 MA 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 with a domestic owner) that is disregarded as an entity separate from its owner under 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-8.*

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 owned by 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 (1-800-829-3676) or from the IRS's Internet Web Site www.irs.gov.

If you do not have a TIN, write "Applied For" in the space for 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 whole 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 to you, mortgage interest you 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 for 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 generally withhold a designated percentage, 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.

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 [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The 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

[1] 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.

[2] Circle the minor's name and furnish the minor's SSN.

[3] 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).

[4] 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.

Form **MA- W-9** (Rev. March 2020)

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

Resources

MassHealth Resources

- MassHealth Website (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)
  - 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.com
    - 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

FAQ

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 or weeks 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 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 of the facility 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 or "unlink" providers who leave a Group Practice?
  - **A:** There is no specific form provided by MassHealth to terminate a link between a Provider and 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 sever the link from. You can also indicate a future date for the link termination 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.

FAQ

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 Individual 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 company (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. In this case, your company would essentially be a "group of one". 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, MA 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 to request PDF 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.

FAQ

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, etc.). 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.

Questions?