Revised 06/14/2021

HCAS HEALTHCARE ADMINISTRATIVE SOLUTIONS, INC.

HCAS Provider Enrollment Form

DATE	COMPLETED BY	TELEPHONE	EMAIL OF PERSON COMPLETING FORM

Section 1: Provider Information

Provider First Name	Middle Initial	Provider Last Name	Degree/Title	Social Security Number	Date of Birth	Gender
						M ☐ F ☐ Non-Binary ☐

Provider Email Address: Languages spoken by provider:

Specialty: Board Certified? Yes ☐ No ☐ If you are not certified, are you eligible? Yes ☐ No ☐ If yes, exam date:

Subspecialty: Board Certified? Yes ☐ No ☐ If you are not certified, are you eligible? Yes ☐ No ☐ If yes, exam date:

CAQH ID:	National Provider Identifier (NPI):	License #	DEA #:

Provider Category	Primary Hospital Affiliation	Secondary Hospital Affiliation	Staff Position	If no hospital affiliation, provide admitting arrangements and MD name
PCP ☐ Specialist ☐ Both ☐ Hospitalist Only ☐ Moonlighter/Covering ☐				

Nurse Practitioner Board Certificate number: Provide collaborating MD For all NP's, PA's and APRN's:

Some emergency medicine, radiologists, anesthesiologists, or pathologists who practice exclusively within a facility and who do not receive direct referrals may qualify for an abbreviated process. Please check here if you meet the criteria. ☐ Will you be billing independently or through a collaborating provider? Ind ☐ CP ☐

Section 2: Primary Practice Information

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group. Use last page to list additional addresses.

Practice Name: _____

Can patients make an appointment at this location? Yes ☐ No ☐

If yes, include this address in health plan directory? Yes ☐ No ☐

If no, reason: _____

Is this your Mailing Address Yes ☐ No ☐ If no, complete last page.

Primary Address: Is this your Credentialing Address Yes ☐ No ☐ If no, complete last page.

Street			
City	State	ZIP Code	Languages Spoken by office staff

Telephone:	Fax:	Practice Email:	Practice Manager Name	Practice Start Date

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Average Waiting Time to Schedule:

Initial Visit	Routine Physical	Urgent Visit

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes ☐ No ☐

Handicap Access: Yes ☐ No ☐

Practice Type: Solo ☐ Partnership ☐ Single ☐ Specialty Group ☐ Multi-Specialty Group ☐ Concierge Model ☐ Other:

Does this office location use an Electronic Medical Record? Yes ☐ No ☐

Does the provider offer telehealth? Yes ☐ No ☐

Section 3: Payment Information

Payee Name: _____ Tax Identification Number _____ Group NPI # _____

Payment Address _____ Street

_____ City _____ State _____ ZIP Code _____ Email

_____ Telephone _____ Fax _____ Contact Name

Section 4: Other Provider Information

What is the provider's status?

☐ Accepting new patients ☐ Accepting existing patients only ☐ Closed (not accepting new patients and not accepting existing patients)

What age groups does the provider treat?

Please list any practice restrictions for the provider:

Does the provider participate in and meet the conditions of participation in Medicare? Yes ☐ No ☐

Does the provider have a current, valid and active Medicare participating PTAN number? Yes ☐ No ☐

If yes, please indicate participating individual PTAN number:

Please indicate individual Medicaid number:

Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes ☐ No ☐

Describe the steps you take to monitor for and prevent discriminatory practices:

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Additional Documents to Submit: Please see *Health Plan Contracting and Enrollment Required Documents List* located on the Credentialing Resources page at **www.hcasma.org.**

Section 5: Submission Information

AllWays Health Partners Credentialing Department 399 Revolution Drive, Suite 820 Somerville, MA 02145 **Fax :** 617-526-1982 **Email :** pec@allwayshealth.org **Provider Service Center :** **Phone :** 800-433-5556	**Blue Cross Blue Shield of MA** **Fax:** 617-246-4227 **Phone:** 800-316-BLUE (2583)	**Boston Medical Center HealthNet Plan** Provider Processing Center 529 Main Street, Suite 500 Charlestown, MA 02129 BMCHP.providerprocessingcenter@bmchp.org **Provider Processing Center:** 888-566-0008 Fax: **617-897-0818**
Fallon Health One Chestnut Place 10 Chestnut Street Worcester, MA 01608 **Fax**: 508-368-9902 **Email:** Askfchp@fallonhealth.org **Provider Services**: 866-275-3247, Opt 4	**Harvard Pilgrim Health Care** Attn: Provider Processing Center 1600 Crown Colony Drive Quincy, MA 02169 **Fax** : 866-884-3843 **Email :** PPC@harvardpilgrim.org **Provider Service Center :** 800-708-4414	**Health New England** Provider Contracting One Monarch Place Suite 1500 Springfield, MA 01144 Phone: 800-842-4464 Fax: 413-233-3175 Email: PContracting@HNE.com
Tufts Health Plan Credentialing Department 705 Mt Auburn Street, 6th Floor Watertown, MA 02472 **Email**: tufts_health_plan_credentialing_department@tufts-health.com **Phone:** 888-306-6307	**Tufts Health Public Plans** Tufts Health Plan Attn: Provider Information 705 Mt Auburn Street, 6th Floor Watertown, MA 02472 **Provider Information Email:** Provider_data_request@tufts-health.com	

Additional Practice Location

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group.

Practice Name: _____

Additional Practice ☐ Mailing Address ☐ Credentialing Address ☐
Can patients make an appointment at this location? Yes ☐ No ☐
If yes, include this address in health plan directory? Yes ☐ No ☐
If no, reason: _____

Address:

Street

City | State | ZIP Code | Languages Spoken by office staff

Telephone: | Fax: | Practice Email: | Practice Manager Name | Practice Start Date

Optional Practice Information

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Average Waiting Time to Schedule:

Initial Visit	Routine Physical	Urgent Visit

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes ☐ No ☐
Handicap Access: Yes ☐ No ☐
Practice Type: Solo ☐ Partnership ☐ Single ☐ Specialty Group ☐ Multi-Specialty Group ☐ Concierge Model ☐ Other:
Does this office location use an Electronic Medical Record? Yes ☐ No ☐
Does the provider offer telehealth? Yes ☐ No ☐

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Additional Practice ☐ Mailing Address ☐ Credentialing Address ☐
Can patients make an appointment at this location? Yes ☐ No ☐
If yes, include this address in health plan directory? Yes ☐ No ☐
If no, reason: _____

Address:

Street

City | State | ZIP Code | Languages Spoken by office staff

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