Request for MassHealth Provider Forms

Please use this form to request a supply of MassHealth forms; using this form will facilitate the handling of your request.

Please print your mailing address clearly:

Provider Name: _____ MassHealth Provider No.: /__/__/__/__/__/__/__/__/

ATTN: _____

Street: _____ (Do not enter a P.O. Box number.)

Suite/Apartment: _____

City/State/Zip: _____

Requestor's Signature: _____ Date:_____

MassHealth Claim Forms (Please check box):		**Quantity**	**(Please check):**
❑ Claim Form 4 – EPSDT	(CLM-4)	_____	__ Forms __ Box(es)
❑ Claim Form 5 – Physician	(CLM-5)	_____	__ Forms __ Box(es)
❑ Claim Form 7 – Transportation	(CLM-7)	_____	__ Forms __ Box(es)
❑ Claim Form 9 – Medical Services	(CLM-9)	_____	__ Forms __ Box(es)
❑ Claim Form 10 – Long Term Care	(CLM-10)	_____	__ Forms __ Box(es)
❑ Claim Form 11 – Dental	(CLM-11)	_____	__ Forms __ Box(es)

Other MassHealth Forms (Please check box):		**Quantity**	**(Please check):**
❑ Ambulance Medical Necessity	(GEN-004)	_____	__ Forms __ Box(es)
❑ Application For Seniors/People Needing LTC	(MHA)	_____	__ Forms __ Box(es)
❑ Certification for Payable Abortion	(GEN-012)	_____	__ Forms __ Box(es)
❑ Disability Supplement for Adults MADS-A	(MHM-010)	_____	__ Forms __ Box(es)
❑ Disability Supplement for Children	(MADS-C)	_____	__ Forms __ Box(es)
❑ Drug Prior Authorization Request	(PA-2)	_____	__ Forms __ Box(es)
❑ Hospice Election Form	(HOS-001)	_____	__ Forms __ Box(es)
❑ Hysterectomy Information Form	(GEN-011)	_____	__ Forms __ Box(es)
❑ MassHealth Fact Sheet (English)	(OP-3)	_____	__ Forms __ Box(es)
❑ MassHealth Fact Sheet (Spanish)	(OP-3 SP)	_____	__ Forms __ Box(es)
❑ Medical Benefit Request (English)	(MBR-1)	_____	__ Forms __ Box(es)
❑ Medical Benefit Request (Spanish)	(MBR-1S)	_____	__ Forms __ Box(es)
❑ Notification of Birth	(AIH-001)	_____	__ Forms __ Box(es)
❑ Prescription for Transportation	(GEN-010)	_____	__ Forms __ Box(es)
❑ Prior Authorization Request	(PA-1)	_____	__ Forms __ Box(es)
❑ Status Change Request	(SC-1)	_____	__ Forms __ Box(es)
❑ Supplemental Dental Prior Authorization Request	(DEN-001)	_____	__ Forms __ Box(es)
❑ Vision Care Materials Request	(VIS-001)	_____	__ Forms __ Box(es)
❑ *Other: _____ (Form Title and Form Number)		_____	__ Forms __ Box(es)

*Use other side if you need more space.

Internal Use Only:
Provider Service Rep. Name: _____ Ext._____ Date: _____/_____/_____

Please fax completed forms to: 703-917-4937, or mail to: MassHealth, Forms Distribution, P.O. Box 9101, Somerville, MA 02145.