Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
All Provider Bulletin 201
February 2010

TO: All Providers Participating in MassHealth

FROM: Terry Dougherty, Medicaid Director

RE: **New Carrier Code Request Form**

Background

A provider can now use the attached carrier code request form to report a commercial health insurance carrier that is not currently on the carrier code list in Appendix C of every MassHealth provider manual. The Third Party Carrier Code Request form is located on the MassHealth Web site at www.mass.gov/masshealth. Click on the link for MassHealth Provider Forms in the lower-right corner of the home page.

The completed form should be faxed to 617-886-8134. You will receive a fax notification once your request has been processed. The new carrier code will be available for use in NewMMIS immediately, so MassHealth can update a member's file with any update request that is received for the new carrier. The new carrier code will be seen on the carrier code list in Appendix C the next time Appendix C is updated.

Please Note: This form should be used for its intended purpose only. It should not be used for any other MassHealth or Third Party Liability (TPL) Unit communications.

Providers should continue to use the Third Party Liability Indicator form to report any changes to a MassHealth member's third-party liability. You should continue to fax these forms to the TPL Unit using the fax number at the bottom of the form.

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

Third Party Carrier Code Request

Date: ______________________

1. Commercial Carrier Information

Insurance Company Name: ______________________

Insurance Company Phone No.: ______________________

Insurance Company Address: ______________________

2. Policyholder and Family Information

Policyholder's Name: ______________________

SSN: ______________________ Date of Birth: ______________________

Policy No.: ______________________ Group No.: ______________________

Policy Start Date: ______________________ Policy End Date: ______________________

Family Members Covered:

Name: ______________________ MassHealth ID No.: ______________________

Name: ______________________ MassHealth ID No.: ______________________

Name: ______________________ MassHealth ID No.: ______________________

Name: ______________________ MassHealth ID No.: ______________________

3. Provider Information

Provider Name: ______________________

Contact Person: ______________________

Contact Phone No.: ______________________

Contact Fax No.: ______________________

Please fax this form to:

617-886-8134

Assistant Manager
Revenue Operations Benefit Coordination