PROVIDER APPLICATION

DOULA GROUP PRACTICE ORGANIZATION (PT-97)

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

APPLICATION TRACKING NUMBER (ATN)						

Print Clear

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
☐ Change of address – PID/SL of the old location _____ Effective date _____
☐ Reactivation – Provider ID Service Location (PID/SL) _____ ☐ Adding New Location (s) – current PID _____

Is the application being submitted as a result of a merger, acquisition, closure, change in corporate structure or other ownership structure? ☐ Yes ☐ No
If Yes, please describe.

_____

SECTION 1: ORGANIZATIONAL INFORMATION

NOTE: The information included in Section 1 **MUST** apply to all service locations included in Section 2. If the information in Section 1 does not apply, a separate provider application must be completed for that service location.

1.1 ORGANIZATION TYPE

☐ Doula Group Practice Organization (PT-97)

1.2 GROUP PRACTICE ORGANIZATION INFORMATION

Legal Name of the Doula Group Practice Organization (also referred to as applicant as reported to the Internal Revenue Service)

Legal Address (address registered with Internal Revenue Service for the doula group practice organization's federal employer identification number (FEIN))

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

Ownership Class ☐ For profit ☐ Private, nonprofit, charitable, or religious ☐ Private, nonprofit, not charitable, or religious

Type of Entity ☐ Business Corporation ☐ Nonprofit Corporation ☐ Partnership ☐ Professional Corporation ☐ Trust
☐ Other (describe) _____ (Note: Sole proprietorship is not an eligible entity type.)

1.3 TAXPAYER IDENTIFICATION NUMBER OF GROUP PRACTICE ORGANIZATION

Federal Employer Identification Number (FEIN)

1.4 MEDICAID INFORMATION FOR OTHER STATES (Attach additional pages, if necessary.)

Does the applicant currently participate, or has 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)

1.5 BILLING ADDRESS (From which the doula group practice organization will submit claims for services)

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

If Yes, applicant need not complete remainder of Section 1.5.

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

1.6 MEDICARE INFORMATION

Is the doula group practice organization 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.

1.7 ENTITY CRIMINAL CONVICTION(S) INFORMATION (Attach additional pages, if necessary.)

Has the group practice organization 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 group practice's organization'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.

Type of Crime		
Date of Conviction	Court/State	Case or Record Number
Type of Crime		
Date of Conviction	Court/State	Case or Record Number
Type of Crime		
Date of Conviction	Court/State	Case or Record Number

1.8 ENTITY SANCTION(S) INFORMATION (Attach additional pages, if necessary.)

Has the group practice organization 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, provide the following information for each such action.

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

1.9 PENDING PROCEEDINGS (Attach additional pages, if necessary.)

Are there any currently pending proceedings that could result in either a criminal conviction reportable in Section 1.7 or other sanction reportable in Section 1.8? ☐ 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

1.10 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.

SECTION 2: SERVICE LOCATION INFORMATION

Please make a copy of Section 2 (pages 5-6) and complete a copy for each nonenrolled service location (SL) where services are provided to MassHealth members.

SERVICE LOCATION (SL) NUMBER ☐ OF ☐

Note: Failure to list in the application all currently nonenrolled locations where services will be provided is a violation of MassHealth regulations 130 CMR 450.222 and 450.223. Please attach each completed copy of Section 2 to the signed application. Each such copy shall become part of the application. Note that each individual practitioner in a group practice organization who either renders services to MassHealth members or (for some types of practitioners) orders, refers, or prescribes services to MassHealth members must also be individually enrolled as a provider with MassHealth.

2.1 SERVICE LOCATION (SL)/ "DOING BUSINESS AS" (DBA) NAME

Enter the group practice's organization's trade name (SL/DBA) and street address, national provider identifier (NPI) number, and all other group practice organization information requested below that is applicable to this service location where services will be provided to MassHealth members. Correspondence will be mailed to this address. Enrollment will not be approved if only a PO box is entered as the address.

Group Practice's Name (Doing Business As (DBA) name)			
Group Practice's Address Number/Street			Building or Suite
City	State	Zip	
ATTN/Title	Email		
Tel.	Fax		
Group Practice's NPI number applicable to this service location		Medicare Number	
Is this a non-billing site? ☐ Yes. If Yes, provide the PIDSL of the billing site		☐ No	

Please note, if this is a non-billing site, then W-9, EFT and ERA forms are not required.

2.2 INDIVIDUAL PRACTITIONERS AT THIS SERVICE LOCATION

List the name(s) of each doula provider who is practicing as part of the group practice organization at this service location, and the individual practitioner's NPI, MassHealth provider ID, and service location (PID/SL). A completed Doula Provider Application (PE-DOULA) must be attached to this application for each such practitioner in the group practice organization who will be rendering services to MassHealth members at this service location and who is not currently enrolled with MassHealth.

The provider type that will be linked to the doula group is C5–doula provider.

Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
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Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	
Last Name	First Name	MI
MassHealth Provider ID (PID/SL) (if applicable)	☐ Check here if individual enrollment is pending or being submitted concurrently.	
Individual Practitioner NPI	Provider Type Code (C5–Doula Provider)	

PLEASE MAKE A COPY of this page if you need to link more practitioners to that service location. Attach each completed copy to the signed application. Each such copy will become part of the application.

SECTION 3: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

I certify that I am duly authorized to act on behalf of the applicant.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments or supplements submitted on behalf of the applicant have been reviewed 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, and that the failure to provide true, accurate, and complete information in this provider application may result in the denial of the applicant's enrollment as a MassHealth provider or the termination of any provider agreement resulting from or related to this provider application. I understand the applicant must notify the MassHealth Provider Enrollment unit of any change in the information submitted in this provider application, its attachments and any applicable supplements, including any information regarding the individual practitioners listed in Section 2, in accordance with and within the time specified in 130 CMR 450.223(B).

Applicant hereby authorizes MassHealth and its designees to access, and agrees to furnish MassHealth upon request, any information MassHealth deems relevant to applicant's eligibility and qualifications to be a participating provider in MassHealth, including information about the professional performance, judgment, clinical skills, character, and ethical qualifications of the individual practitioners who are part of the group practice organization that the applicant has in its possession, custody, or control, including otherwise privileged or confidential information. I understand and agree that the applicant has the burden to produce adequate information to MassHealth to permit evaluation of the applicant's eligibility and qualifications to be a participating provider in MassHealth, and for resolving any doubts that MassHealth may have about the applicant's 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

Printed Legal Name of Individual Signing on Behalf of Applicant

Title/Relationship to Applicant

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.

Print Clear

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.