PROVIDER APPLICATION

DOULA PROVIDERS

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 ☐ Reactivation – Provider ID Service Location (PID/SL) _____

SECTION 1: APPLICANT INFORMATION

1.1 APPLICATION TYPE

Provider type: **C5 DOULA PROVIDER**

Is the applicant enrolling as ☐ An individual practitioner practicing independently ☐ Part of a group practice organization ☐ Both

Note: This application is for individual doulas, 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, non-billing applicants (also known as Ordering, Referring, and Prescribing Providers), or managed care entity (MCE) applicants.

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 Legal Address/Home Street Address

City | State | Zip

ATTN/Title | Email

Tel. | Fax

1.3 MEDICAID INFORMATION FOR OTHER STATES

Does the applicant currently participate, or have they 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 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.

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	

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	

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 doula.

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

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

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.

SECTION 5: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

I certify that I am a doula applying to enroll in MassHealth as a participating provider.

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.

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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.