COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Nonbilling Provider Contract for Individuals

(also known as Ordering, Referring, and Prescribing Providers)

This Nonbilling Provider Contract (this "Contract") is between the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (hereinafter MassHealth), and

_____

(Legal Name of Nonbilling Provider, hereinafter the "Nonbilling Provider")

In consideration of the mutual promises contained herein, the parties agree as follows.

I. The Nonbilling Provider agrees:

A. and understands that they are enrolling in MassHealth as a nonbilling provider because their National Provider Identifier (NPI) is or may be included on claims submitted by a MassHealth-participating billing provider;

B. and understands that they may order, refer, prescribe, provide, or supervise the ordering, referring, prescribing, or provision of services to MassHealth members within the scope of their licensure, but shall not submit claims to or receive payments from MassHealth;

C. to comply with all state and federal statutes, rules, and regulations applicable to the nonbilling provider's participation in MassHealth;

D. to order, refer, prescribe, or provide services to eligible members without regard to religion, race, color, or national origin in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq. and its implementing regulations at 45 CFR Part 80), and without regard to disability in compliance with Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794 and its implementing regulations at 45 CFR Part 84), and without regard to age in compliance with Section 6102 of the Age Discrimination Act of 1975 (42 U.S.C.§6101 et seq. and its implementing regulations at 45 CFR Part 90.1 et seq. and 45 CFR Part 617);

E. to keep such records as are necessary to disclose fully the extent and medical necessity of the services that the nonbilling provider orders, refers, prescribes, or provides to MassHealth members and to preserve these records for at least six years, or for such a length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer;

F. to furnish MassHealth, the United States Secretary of Health and Human Services, the Attorney General's Medicaid Fraud Division, the State Auditor, and any other state and federal agency to which disclosure is required by law, upon request, with such information, including copies of medical records, about any services that the nonbilling provider orders, refers, prescribes, or provides to MassHealth members;

G. to comply with the federal disclosure requirements specified in 42 CFR Part 455, Subpart B;

H. to furnish to MassHealth the nonbilling provider's national provider identifier (NPI), and include such NPI on all orders, referrals, and prescriptions for MassHealth members;

I. to permit the federal Centers for Medicare & Medicaid Services and the MassHealth agency, and their agents and designated contractors, to conduct unannounced onsite inspections of any and all provider locations for the limited purpose of investigating suspected fraud or abuse related to MassHealth; and

J. to notify MassHealth within 14 days of any changes in the information submitted on their application.

II. The Nonbilling Provider and MassHealth mutually agree:

A. that any Special Conditions that indicate they are to be incorporated into this Contract and that are signed by both parties to this Contract will be deemed to be part of this Contract and that in the event of any inconsistency between the Special Conditions and this Contract, the former shall control; and

B. that this Contract shall take effect upon notification of acceptance by MassHealth and shall continue in effect until terminated by either party upon written notice to the other party; and that MassHealth may not terminate this Contract without affording to the nonbilling provider any applicable right to contest such termination available under federal and state law and regulation that has been properly requested by the provider.

Nonbilling Provider

_____

(Legal Name of Nonbilling Provider)

By: _____ Name: _____

(Signature) (Printed Name)

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.

Title: _____ Date: _____

Do not write below this line.

Executive Office of Health and Human Services

Executive Office of Health and Human Service

By: _____

(Signature)

Name: _____

(Printed Name)

Title: _____ Date: _____

PROVIDER APPLICATION

NONBILLING PROVIDER
(also known as Ordering, Referring, and Prescribing Providers)

APPLICATION TRACKING NUMBER (ATN)						

Print Clear

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

Please ensure that all sections of this application are completed before submission.

CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS APPLICATION (MassHealth may contact you if there are questions about this application.)

Name	Tel.
Email	

This form should not be used if you are a provider participating solely in a MassHealth-contracted MCE network and seeking enrollment to meet the federal regulations at 42 CFR 438.602(b) and 608(b) that require such enrollments.

This form is used to enroll providers who do not submit claims to or receive payment from MassHealth but whose National Provider Identifier (NPI) is included on claims submitted by billing providers. This includes pharmacists who have a Controlled Substance Registration number (MCSR) that authorizes them to prescribe medications, as well as providers applying to receive their MA professional license.

Massachusetts state law (M.G.L. c. 112) requires, as a condition of obtaining and maintaining state licensure, that providers who are authorized ordering, referring, and prescribing (ORP) providers apply to enroll in MassHealth as either a non-billing provider or a fully participating provider. The list of provider types that are authorized ORP providers is identified in Section 1 of this application.

Please note that MassHealth does not consider an application to be completed until all requested information is provided in accordance with the application instructions herein. If MassHealth determines that an application is incomplete or incorrectly completed, MassHealth will notify the applicant in writing. MassHealth may report applicants who have not appropriately completed their application to their respective licensing board, which may result in further action under the applicable provisions of M.G.L. c. 112.

All providers whose NPI must be included on claims due to any state or federal requirement, such as the ordering and referring requirement referenced later, HIPAA 5010, or other requirements; and providers whose NPI is included on a claim by a billing provider for other reasons, must be enrolled with MassHealth at least as a nonbilling provider in order for the billing provider to receive payment for the claim.

For example, if MassHealth requires a service to be ordered, referred, or prescribed by any of the provider types listed in Section 1 of this form, then, in order for the billing provider to receive payment for that service, federal law requires that:

1. the ordering, referring, or prescribing provider's NPI must be included on the billing provider's claim; and
2. the ordering, referring, or prescribing provider be enrolled with MassHealth at least as a nonbilling provider.

This requirement applies to independent providers and pharmacists who are authorized to prescribe medications, and facility-based providers. In addition, when a clinician not listed in Section 1 (which follows) orders or refers a service, then the NPI of a provider listed in Section 1, such as the supervising physician's NPI, must be included on the claim. In that situation, the physician must also be enrolled at least as a nonbilling provider in order for the ordered, referred, or prescribed service to be payable by MassHealth.

Note, however, that this form should not be used for providers who work in a group practice, since those providers must be fully enrolled with MassHealth.

Providers enrolled in MassHealth through this form are not permitted to submit claims to or receive payment from MassHealth. Providers who are in a category that MassHealth recognizes as billing providers and who wish to enroll in MassHealth as a billing provider should contact MassHealth at (800) 841-2900, TDD/TTY: 711 to request an enrollment packet.

You should have already obtained an individual NPI from an NPI Enumerator. You should ensure that the Primary Practice Address registered with the NPI Enumerator reflects the street address entered in the Primary Service Location portion of this application associated with the organization with which you are affiliated. Additionally, prescribers writing prescriptions for CII–CV medications are required to enter a U.S. Drug Enforcement Administration (DEA) number.

If you are not fully licensed, and have limited license status, please attach a copy of your limited license to your application.

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.

SECTION 1: APPLICANT INFORMATION

Legal Name of Applicant

Applicant's Date of Birth | Applicant's Social Security Number (SSN)

☐ SSN pending. Please explain:
Note: Your application will not be approved by MassHealth without an SSN. MassHealth will pend this application until the SSN is obtained.

Applicant's Individual National Provider Identifier Number (NPI). (You must obtain an NPI before submitting this application.)

Home Street Address

City | State | Zip

Tel. | Fax

Email

Provider type (Interns, residents, and other trainees authorized to order, refer, or prescribe services must check the relevant provider type below and submit a copy of their limited license with this application.)

☐ PT 01: Physician
☐ PT 02: Optometrist
☐ PT 05: Psychologist
☐ PT 06: Podiatrist
☐ PT 08: Certified Nurse Midwife
☐ PT 10: Dentist*
☐ PT 17: Certified Nurse Practitioner
☐ PT 39: Physician Assistant
☐ PT 51: Certified Registered Nurse Anesthetist
☐ PT 57: Clinical Nurse Specialist
☐ PT 78: Psychiatric Clinical Nurse Specialist
☐ PT 90: ☐ CDTM Pharmacist OR ☐ Pharmacist - Other**
☐ PT 92: Licensed Independent Clinical Social Worker

* For dental providers, contact the MassHealth Dental Customer Service Center at (800) 207-5019. Dentists should submit the form and signed contract by mail to DentaQuest at MassHealth Dental Program, Attn: Provider Enrollment and Credentialing, PO Box 2906, Milwaukee, WI 53201-2906.

** Pharmacists who have not entered into a Collaborative Drug Therapy Management (CDTM) agreement but who wish to enroll to prescribe drugs or non-drug products to the extent permitted by state law should enroll using this provider type. Such pharmacists are not required to enroll as ORP providers under state law but may choose to do so.

Applicant's Massachusetts license number* _____

☐ Check box if you are applying or your Massachusetts license is pending. You must indicate an approximate expected issue date: _____ .
☐ Check box if your Massachusetts license is a limited status. You must attach a copy of the limited license to this application.
☐ Check box if you are an Indian Health Services provider with a license in another state.
☐ Check box if you are a federal employee with a license in another state.

* Unless you are an Indian Health Services provider with a license in another state, or a federal employee with a license from another state, your application will not be approved by MassHealth without a license. If you are applying to MassHealth while also in the process of obtaining your Massachusetts license and/or applicable DEA number, MassHealth will pend this application for up to six months or until the license and DEA number (if applicable) are obtained. If your MA license and/or DEA number are not obtained within the allowed time frame, you must re-apply.

Does the applicant hold a license from another state? ☐ Yes ☐ No		State	License Number
State	License Number	State	License Number
State	License Number	State	License Number

Applicant's primary Massachusetts DEA number* _____ .

☐ Check box if the DEA number is that of the primary affiliated institution**.
☐ Check box if prescribing only Schedule VI drugs.
☐ Check box if in a provider type that is authorized to prescribe, but you are not prescribing.
☐ Check box if you are applying or your DEA application is pending (send DEA number to MassHealth once assigned).

* With the exception of providers prescribing only Schedule VI drugs, providers must have a DEA number in order to prescribe medications.
** Providers authorized to prescribe under their affiliated hospital's DEA registration number must enter that institution's DEA number.

Applicant's Out-of-State DEA number (if applicable):	For which state does the applicant have a DEA number?

Are you permitted to prescribe buprenorphine for medication-assisted treatment as evidenced by possessing an X DEA number? ☐ Yes ☐ No

If Yes, is please provide X DEA number and date of issuance.

CDTM Pharmacist Applicants Only: Massachusetts Controlled Substance Registration (MCSR) Number

PRIMARY SERVICE LOCATION (PSL) (All applicants must complete this section. If you do not have a PSL enter your home address.)

Street Address (Street address only; no PO boxes are allowed.)

City	State	Zip

Tel.	Fax

Email

Preferred Contact Name

Preferred Contact Email	Tel.

Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site? ☐ Yes ☐ No

If Yes, is the applicant on staff and working as a primary care provider at this service location? ☐ Yes ☐ No

If Yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology? ☐ Yes ☐ No

Any applicant who is a primary care provider for MassHealth Primary Care Clinician (PCC) Plan members at additional community health center, acute hospital outpatient department, hospital-licensed health center, or Indian Health Service sites must complete a Service Location section for each such additional site.

CDMT PHARMACISTS ONLY:
Please provide the following information for each supervising physician with whom you have a collaborative practice agreement.

1) Supervising Physician Name	4) Supervising Physician Name
Supervising Physician's Individual National Provider Identifier (NPI)	Supervising Physician's Individual National Provider Identifier (NPI)
2) Supervising Physician Name	5) Supervising Physician Name
Supervising Physician's Individual National Provider Identifier (NPI)	Supervising Physician's Individual National Provider Identifier (NPI)
3) Supervising Physician Name	6) Supervising Physician Name
Supervising Physician's Individual National Provider Identifier (NPI)	Supervising Physician's Individual National Provider Identifier (NPI)

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE LOCATIONS. **NUMBER ☐ OF ☐**

Service Location (SL) (if different than home address)

Street Address (Street address only; no PO boxes are allowed.)

City | State | Zip

Tel. | Fax

Email

Preferred Contact Name

Preferred Contact Email | Tel.

Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site? ☐ Yes ☐ No

If Yes, is the applicant on staff and working as a primary care provider at this service location? ☐ Yes ☐ No
If Yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology? ☐ Yes ☐ No

Street Address (Street address only; no PO boxes are allowed.)

City | State | Zip

Tel. | Fax

Email

Preferred Contact Name

Preferred Contact Email | Tel.

Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site? ☐ Yes ☐ No

If Yes, is the applicant on staff and working as a primary care provider at this service location? ☐ Yes ☐ No
If Yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology? ☐ Yes ☐ No

SECTION 2: DISCLOSURES (For additional information, see 42 CFR § 455.106, 42 CFR 455.436, and 42 CFR §1002.3.)

2A. OWNERS, MANAGING EMPLOYEES, AND AGENTS OF APPLICANT

Please read the following criteria to determine if you are required to complete this section. If not, please check "None."
Note: It is less common for applicants practicing solely as an employee of an organization to have relationships described in this section. It is more common for applicants who participate in a group practice or who have an office manager, billing agent, or similar staff, to have relationships described in this section.

Disclose any individual or entity that meets at least one of the following criteria (check "NONE" if none).

i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the applicant
ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the applicant or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the applicant
iii. Is an officer or director of the applicant, if the applicant is organized as a corporation
iv. Is a partner in the applicant, if the applicant is organized as a partnership
v. Is an agent of the applicant
vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the applicant or part thereof, or directly or indirectly conducts the day-to-day operations of the applicant or part thereof
vii. Was formerly described in 2.A.i through 2.A.vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household

The definitions applicable to this section are as follows.

- *Agent* means any person who has express or implied authority to obligate or act on behalf of applicant (e.g., office manager, billing agent).
- *Immediate family member* means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- *Indirect ownership interest* includes an ownership interest through any other entities that ultimately have an ownership interest in the applicant (e.g., an individual has a 10 percent ownership interest in the applicant if they have a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the applicant).
- *Member of household* means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.
- *Ownership interest* means an interest in:
  - the capital, the stock, or the profits of the applicant; or
  - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the applicant.

List any familial relationships (spouse, parent, child, sibling) to the applicant and/or any other disclosed individual described above. If additional space is needed, please copy this page and attach to application.

☐ None (if None, continue to Section B)			
Name of Individual or Entity	☐ Has ownership or control.*	☐ Managing Employee*	☐ Agent*
Percent of Ownership (if applicable)	NPI (if applicable)		
Title, Function, or Association to Applicant			
Address(es) (city, state, zip; home if individual/business; headquarters; and PO boxes if entity)			
SSN (if individual)/TIN (if entity)	Date of Birth (if individual)		
Familial Relationship (if individual, if any)			

* For clarification and definition of the choices, please see the top of Section 2A.

2B. DISCLOSURES

Respond to the following questions on behalf of the applicant AND any individuals/entities identified in Section 2.A. If you answer Yes to any question, provide a detailed explanation in Section 2.C, including the name of the individual/entity; the nature, date, and forum of the action; and any case or record number.

Has any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?	☐ Yes	☐ No
Has any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?	☐ Yes	☐ No
Has any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?	☐ Yes	☐ No
Has any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?	☐ Yes	☐ No
Has any of the individuals/entities ever been subject to disciplinary action by a licensing board in any state?	☐ Yes	☐ No

2C. ADDITIONAL EXPLANATION

If you answered Yes to any question in Section 2.B, you must provide a detailed explanation below, including the name of the individual/entity; the nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 3: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that if MassHealth determines that I have not appropriately completed my application, MassHealth may notify the applicable licensing board, which may result in further action under the applicable provisions of M.G.L. c. 112. 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.

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 | 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.

Return your completed application packet by fax or mail to MassHealth.

Print Clear

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.