COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

MassHealth Nonbilling Provider Contract for Individuals

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 he or she is enrolling in MassHealth as a nonbilling provider because his or her National Provider Identifier (NPI) is or may be included on claims submitted by a MassHealth-participating billing provider;

B. and understands that he or she may order, refer, prescribe, provide, or supervise the ordering, referring, prescribing, or provision of services to MassHealth members within the scope of his or her 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 his or her 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: _____

(Signature)

Name: _____

(Printed Name)

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

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 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.

All providers whose NPI must be included on claims due to any state or federal requirement, such as the ordering and referring requirement referenced below, 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.

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 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 as well as facility-based providers. In addition, when a clinician not listed in Section 1 below 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 would also need to enroll as a nonbilling provider.

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.

Please also note that there is also a separate nonbilling provider application for pharmacists who are authorized to prescribe. Please call MassHealth Customer Service (CSC) at the number listed below to request the pharmacist application if you qualify as a pharmacist who is authorized to prescribe.

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 Customer Service at 1-800-841-2900 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. If you are authorized to prescribe medications, you are required to enter a Primary Taxonomy Code that indicates that you have the appropriate clinical discipline to write a prescription. Additionally, prescribers writing prescriptions for CII–CV medications are required to enter a DEA number.

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

Please complete, sign, and return this form and the Nonbilling Provider Contract by mail to the MassHealth Customer Service Center (CSC), Attn: Provider Enrollment, P.O. Box 121205, Boston, MA 02112-1205. You can address questions about the form to CSC. Dentists should submit the form and signed contract by mail to DentaQuest at MassHealth Dental Program, Attn: Provider Enrollment and Credentialing, P.O. Box 2906, Milwaukee, WI 53201-2906. All information is subject to audit.

SECTION 1: APPLICANT INFORMATION

Legal name of applicant

Applicant's date of birth | Applicant's SSN

☐ SSN pending. Please explain:

Note: Your application will not be approved by MassHealth without a social security number. MassHealth will pend this application until the SSN is obtained.

Applicant's individual National Provider Identifier Number (NPI)

Provider type (Interns, residents, and other trainees authorized to order, refer, or prescribe services should 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 92: Licensed Independent Clinical Social Worker

Applicant's primary Massachusetts DEA number* _____

☐ Check box if the DEA 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 your DEA number is pending subject to Massachusetts license approval.

* Note that, 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 should 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?

Applicant's Massachusetts license number

☐ Applicant's Massachusetts license pending | Anticipated issue date of license

Note: 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. MassHealth will pend this application until the license is obtained.

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

Home street address

City | State | Zip

Tel. | Fax

Email

Primary Service Location (PSL) (All applicants must complete this section if PSL if different than home address)

Name of facility where you will be, or are, working at (if applicable)

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.

Name of facility where you will be, or are, working at (if applicable)

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

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

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

Name of facility where you will be, or are, working at (if applicable)

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

Name of facility where you will be, or are, working at (if applicable)

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*

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

Please read the criteria below 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 below 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 he or she has 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 he or she is 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.

* For additional information, see 42 CFR § 455.106, 42 CFR 455.436, and 42 CFR §1002.3.

☐ 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 above.

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 above.

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 I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Printed Legal Name of Applicant

Signature

Date

Print Clear

Note: Signature stamps, date stamps, or the signature of anyone other than the applicant are not acceptable.