

Provider Group Data Form



Submit completed form to:

Email: BHPProviders@wellsense.org
Fax: 617-951-3419

To ensure accurate record set-up, please complete one form per NPI.
A current W-9 must be submitted with this form.

Provider Demographics *(To be displayed in Provider Directory)*

Group Name (DBA Name):			
Street Address:			
City/Town:	State:	Zip Code:	County:
Telephone #:	Fax #:		
NPI:	Tax ID:		
Website:			

Parent or Contracting Entity *(If different than above)*

Legal Business Name (same as W-9):			
Street Address:			
City/Town:	State:	Zip Code:	County:
NPI:	Tax ID:		

Billing Information

Billing Name (same as W-9):			
Billing Address:			
Payee Name:			
Billing City/Town:	State:	Zip Code:	County:
Billing Telephone #:	Billing Fax #:		
NPI:	Tax ID:		
Medicare Number:			
Medicaid Number:			State:

Accessibility

Genders Served: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ages Treated: <input type="checkbox"/> 0-21 <input type="checkbox"/> 22-65 <input type="checkbox"/> 66 and over
Language Capabilities: <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese (Cantonese and Mandarin) <input type="checkbox"/> Haitian-Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese (Khmer) <input type="checkbox"/> Other:	

Hours of Operation:

Monday	Start:	End:
Tuesday	Start:	End:
Wednesday	Start:	End:
Thursday	Start:	End:
Friday	Start:	End:
Saturday	Start:	End:
Sunday	Start:	End:

Telehealth Services Available: Yes No

Handicapped Accessibility

- | | | |
|---|---|---|
| <input type="checkbox"/> Accessible Examination Table | <input type="checkbox"/> Accessible Restrooms | <input type="checkbox"/> Accessible Scales |
| <input type="checkbox"/> Accessible via Public Transportation | <input type="checkbox"/> Bariatric Examination Tables | <input type="checkbox"/> Bariatric Scale |
| <input type="checkbox"/> Elevators in Multistory Buildings | <input type="checkbox"/> Exterior Building | <input type="checkbox"/> Gurneys and Stretchers |
| <input type="checkbox"/> Handicap Parking | <input type="checkbox"/> Interior Building | <input type="checkbox"/> Portable Lifts |
| <input type="checkbox"/> Radiologic Equipment | <input type="checkbox"/> Signage & Documents | <input type="checkbox"/> Signs in Braille |
| <input type="checkbox"/> TTY for Patient Services | <input type="checkbox"/> Wheelchair Accessible Exam Rooms | <input type="checkbox"/> Wheelchair Ramps |

Other

- Please answer all of the questions by checking the appropriate "Yes" or "No" box.
- If you answered "yes", please include a copy of your certificate.

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a minority owned business? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a Woman owned business enterprise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a Veteran owned business enterprise? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you a LGBT owned business enterprise? |

Ownership/Management Information

- Please include separate attachment for additional information.

President/Chief Executive Officer N/A

Name:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:

Chief Financial Officer N/A

Name:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:

Medical Director/Chief Medical Officer N/A

Name:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:

Contract Administrator or Managed Care Liaison N/A

Name:	Email:
Street Address:	City/State/Zip:

Phone & Ext:	Fax:
Billing Contact <input type="checkbox"/> N/A	
Name:	
Email:	Title:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Credentialing Contact <input type="checkbox"/> N/A	
Name:	
Email:	Title:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (1) <input type="checkbox"/> N/A	
Name:	Type:
Title:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (2) <input type="checkbox"/> N/A	
Name:	Type:
Title:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (3) <input type="checkbox"/> N/A	
Name:	Type:
Title:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:

Definitions:

- An **Owner** is a person or business entity which owns 5% or more of the assets, stock or profits of this facility. This 5% may be direct ownership, indirect ownership or a combination of both.
- An **Agent** is an individual who has been delegated the authority to obligate or act on behalf of this facility.
- A **Subcontractor** is someone to which this facility has contracted or delegated some of its management functions or responsibilities.
- A **Managing Employee** is someone who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution.

Failure to complete all sections may result in a delayed processing.