Facility/Ancillary Data Form

WellSense HEALTH PLAN

Massachusetts Providers:	New Hampshire Providers:
Email: Provider.ProcessingCenter@wellsense.org Fax: 617-897-0818	Email: NHProvider.Enrollment@wellsense.org Fax: 866-779-5948

To ensure accurate record set-up, please complete one form per NPI.

Provider Demographics *(To be displayed in Provider Directory)*			
Facility/Provider 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:**	
Currently participating in Medicare? ☐ Yes ☐ No		**Medicare Number:**	
Currently participating in Medicaid? ☐ Yes ☐ No		**Medicaid Number:**	**State:**

Provider Type

- *Check off services which only apply to the NPI listed on this form.*
- *Submit an additional Facility/Ancillary Provider Data Form for additional NPIs.*
- *If you do not see your provider type listed, please contact your Contract Manager*

☐ Acute Rehabilitation Hospital	☐ Adult Day Health	☐ Adult Foster Care
☐ Adult Medical Day Care	☐ Aging Service Access Point	☐ Ambulatory Surgical Center
☐ Assisted Reproduction Technology Center	☐ Cardiac Monitoring	☐ Chronic Disease Hospital
☐ Clinical Medical Laboratory	☐ Community Health Center	☐ Convenience Care Clinic
☐ Day Habilitation	☐ Dialysis	☐ Durable Medical Equipment
☐ Early Intervention	☐ Environmental Accessibility	☐ Family Planning Facility
☐ Federally Qualified Health Center	☐ Freestanding Birthing Center	☐ Freestanding Hyperbaric Oxygen Center

☐ Functional Therapies Provider	☐ General Acute Care Hospital	☐ Genetics Lab
☐ Group Adult Foster Care	☐ Group Foster Care	☐ Hearing Aide Equipment
☐ Home Anticoagulation Monitoring	☐ Home Infusion	☐ Home Health Services *(Non-Medical, Home Health Aid)*
☐ Home Health Care *(Medical, Nursing, PT/OT)*	☐ Hospice	☐ Indian Health Services
☐ Interpreter Services	☐ Lactation Services	☐ Mammography Center
☐ Medical Rehabilitation (Non-Acute)	☐ MRI Center	☐ Personal Care Attendants
☐ PET Imaging Center	☐ Private Duty Nursing (☐ Adults) (☐ Peds)	☐ Radiation Therapy
☐ Radiology Center	☐ Rural Health Center	☐ Skilled Nursing Facility
☐ Sleep Laboratory	☐ Speech, Language and Hearing Services	☐ Ultrasound/Vascular Imaging
☐ Urgent Care Center	☐ Veteran's Facility	

Accessibility

Genders Served: ☐ Male ☐ Female

Ages Treated: ☐ 0-21 ☐ 22-65 ☐ 66 and over

Language Capabilities: ☐ Cambodian ☐ Chinese (Cantonese and Mandarin) ☐ Haitian-Creole ☐ Portuguese ☐ Russian ☐ Spanish ☐ Vietnamese (Khmer) ☐ 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

If Yes, please indicate which modalities are available:

☐ Interactive audio-video technology
☐ Remote patient monitoring devices
☐ Audio-only telephone
☐ Online adaptive interviews (i.e., patient questionnaires in preparation for a telehealth visit)

Is your office available for consultation to treat a patient only via Telehealth (answering yes means you are not scheduling face-to-face patient visits) ☐ Yes ☐ No

Location of home-based services: List all counties where services are rendered (if applicable):

Services

☐ Ambulance (Emergency)	☐ Hearing Services	☐ Hospice
☐ Language Services	☐ Occupational Therapy	☐ Physical Therapy
☐ Renal Dialysis Services	☐ Respite Care	☐ Speech Services
☐ Speech Language Therapy		

Accessibility to Services

☐ Adults with Severe Physical Disabilities
☐ Autism Services
☐ Bilingual or Multi-lingual Abilities
☐ Children and Adolescents
☐ Visually Impaired
☐ Geriatric Patients (65+)
☐ Homeless Patients
☐ HIV/AIDS Patients
☐ Children with Severe Physical Disabilities
☐ American Sign Language
☐ Translation Services
☐ Children in the Care or Custody of DCF or Youth Affiliated with DYS

Handicapped Accessibility

Is your office ADA accessible for all physical, developmental and intellectual disabilities? ☐ Yes ☐ No

☐ Accessible Examination Table
☐ Accessible Restrooms
☐ Accessible Scales
☐ Accessible via Public Transportation
☐ Bariatric Examination Tables
☐ Bariatric Scale
☐ Elevators in Multistory Buildings
☐ Exterior Building
☐ Gurneys and Stretchers
☐ Handicap Parking
☐ Interior Building
☐ Portable Lifts
☐ Radiologic Equipment
☐ Signage & Documents
☐ Signs in Braille
☐ TTY for Patient Services
☐ Wheelchair Accessible Exam Rooms
☐ 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.*

☐ Yes ☐ No Are you a minority owned business?
☐ Yes ☐ No Are you a Woman owned business enterprise?
☐ Yes ☐ No Are you a Veteran owned business enterprise?
☐ Yes ☐ No Are you a LGBT owned business enterprise?

Credentialing Checklist

- *Copies of the following documentation must be submitted with your completed application if applicable.*
- *Check the "N/A" box for elements that do not apply.*

☐ Attached ☐ N/A **State license and Pending renewal documents**
License Number: _____ *Expiration Date*: _____

☐ Attached ☐ N/A **Federally Required Disclosures form** *(Required for MassHealth networks only)*

☐ Attached ☐ N/A **Professional Liability Insurance Policy Face Sheet**
Policy Number: _____
Issue Date: _____ *Per Incident $*: _____
Expiration Date: _____ *Per Aggregate $*: _____

☐ Attached ☐ N/A **Drug Enforcement Agency (DEA) Certificate**
DEA Number: _____ *Expiration Date*: _____

☐ Attached ☐ N/A **Clinical Laboratory Improvement Amendments (CLIA) certificate**
CLIA ID: _____ *Expiration Date*: _____

☐ Attached ☐ N/A **Letter / Certificate from National Accreditation Organization**
Org Name: _____
Issue Date: _____ *Expiration Date*: _____

☐ Attached ☐ N/A **Copy of most recent CMS or Department of Health survey report**
Survey Date: _____

☐ Attached	☐ N/A	**Corrective Action Plan (if survey resulted in 5 or more deficiencies)**
☐ Attached	☐ N/A	**Complaint surveys, if applicable**
☐ Attached	☐ N/A	**Evidence of Medicare enrollment, if applicable**
☐ Attached	☐ N/A	**Evidence of Medicaid enrollment, if applicable**
☐ Attached	☐ N/A	**Current W-9**

Attestation Questionnaire

- *Please answer all of the questions by checking the appropriate "Yes" or "No" box.*

☐ Yes	☐ No	Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense?
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever had its accreditation revoked or suspended?
☐ Yes	☐ No	Has this facility, under any current or former name or business entity, ever been suspended or excluded from participation in, or any sanction imposed by a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?
☐ Yes	☐ No	Is this facility, under any current or former name or business entity, currently suspended from Medicare payment under any Medicare billing number?

Provide a full detailed explanation for any question that is answered "Yes". Please attach an additional page if necessary.

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	☐ *N/A*
Name:	
Email:	Title:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Credentialing Contact	☐ *N/A*
Name:	
Email:	Title:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (1)	☐ *N/A*
Name:	Type:
Title:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (2)	☐ *N/A*
Name:	Type:
Title:	Email:
Street Address:	City/State/Zip:
Phone & Ext:	Fax:
Owner, Agent, Subcontractor or Other Managing Employee (3)	☐ *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.

Release of Information and Authorization	
I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in, or omissions from this application constitute cause for denial or summary dismissal. Further, I give permission to verify the organizational providers credentials and by doing so, hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.	
Signature:	Date:
Print Name:	Title:

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