

**Behavioral Health  
Facility/Ancillary Data Form**



<b>Submit completed form to:</b>
Email: bhproviders@wellsense.org
Fax: (800) 894-0459

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

<b>Provider Demographics</b> <i>(To be displayed in Provider Directory)</i>			
<b>Facility/Provider Name (DBA Name):</b>			
<b>Street Address:</b>			
<b>City/Town:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>
<b>Telephone #:</b>	<b>Fax #:</b>		
<b>NPI:</b>	<b>Tax ID:</b>		
<b>Website:</b>			

<b>Parent or Contracting Entity</b> <i>(If different than above)</i>			
<b>Legal Business Name (same as W-9):</b>			
<b>Street Address:</b>			
<b>City/Town:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>
<b>NPI:</b>	<b>Tax ID:</b>		

<b>Billing Information</b>			
<b>Billing Name (same as W-9):</b>			
<b>Billing Address:</b>			
<b>Payee Name:</b>			
<b>Billing City/Town:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>
<b>Billing Telephone #:</b>	<b>Billing Fax #:</b>		
<b>NPI:</b>	<b>Tax ID:</b>		
<b>Currently participating in Medicare?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicare Number:</b>	
<b>Currently participating in Medicaid?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medicaid Number:</b>	<b>State:</b>

## 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

- |                                                                                 |                                                                                               |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Behavioral Health Hospital                             | <input type="checkbox"/> BH Urgent Care Center                                                |
| <input type="checkbox"/> Certified Community Behavioral Health Clinic (CCBHC)   | <input type="checkbox"/> Children's Residential Treatment Facility (Mental Illness; Psych)    |
| <input type="checkbox"/> Children's Substance Abuse Rehabilitation Facility     | <input type="checkbox"/> Community Behavioral Health Center (CBHC)                            |
| <input type="checkbox"/> Community Health Centers (CHC)                         | <input type="checkbox"/> Community Mental Health Center (CMHC)                                |
| <input type="checkbox"/> Federally Qualified Health Center (FQHC)               | <input type="checkbox"/> Inpatient Psychiatry                                                 |
| <input type="checkbox"/> Intensive Outpatient Facility                          | <input type="checkbox"/> Mental Health Residential Treatment Facility (Mental Illness; Psych) |
| <input type="checkbox"/> Opioid Treatment Program (OTP)                         | <input type="checkbox"/> Outpatient Behavioral Health Clinic                                  |
| <input type="checkbox"/> Short Term Care for Involuntary Psychiatric Admissions | <input type="checkbox"/> Substance Abuse Rehabilitation 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:

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

## Services

### Inpatient

- |                                                                                                      |                                                                        |
|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Developmentally Disabled Unit (DDU)                                         | <input type="checkbox"/> Inpatient Mental Health - Adult               |
| <input type="checkbox"/> Inpatient Mental Health - Youth                                             | <input type="checkbox"/> Inpatient Substance Abuse Services (Level IV) |
| <input type="checkbox"/> Medically Managed Inpatient Hospital Withdrawal Management (ASAM Level 4.0) | <input type="checkbox"/> Observation Holding Beds                      |
|                                                                                                      | <input type="checkbox"/> Observation Holding Beds - Youth              |

### Diversionsary

- |                                                                                                                                                |                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Acute Treatment Services for Substance Abuse (ATS) (ASAM Level 3.7)                                                   | <input type="checkbox"/> Adult Community Crisis Stabilization (ACCS)                             |
| <input type="checkbox"/> Assertive Community Based Treatment (ACT)                                                                             | <input type="checkbox"/> Clinical Stabilization Services (CSS) (ASAM Level 3.5)                  |
| <input type="checkbox"/> Community Based Acute Treatment - Child, Adolescents (CBAT)                                                           | <input type="checkbox"/> Community Support Program (CSP)                                         |
| <input type="checkbox"/> Community Support Program - Homeless Individuals (CSP- HI)                                                            | <input type="checkbox"/> Community Support Program - Justice Involved (CSP- JI)                  |
| <input type="checkbox"/> Community Support Program - Tenancy Preservation Program (CSP- TPP)                                                   | <input type="checkbox"/> Co-occurring Enhanced Residential Rehab Svcs (COE-RRS) (ASAM Level 3.1) |
| <input type="checkbox"/> Crisis Stabilization - Adolescent                                                                                     | <input type="checkbox"/> Crisis Stabilization - Child                                            |
| <input type="checkbox"/> Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders | <input type="checkbox"/> Family Stabilization Team Services (FST)                                |

- Family Support and Training (FS&T) - (CBHI)
- High intensity Residential Treatment (ASAM Level 3.5)
- In-Home Behavioral Services (IHBS) - (CBHI)
- Intensive Care Coordination (ICC) - (CBHI)
- Intensive Hospital Diversion (IHD)
- Intensive Outpatient Treatment (IOP) for SUD (ASAM Level 2.1)
- Low- Intensity Residential Treatment - Adult (ASAM Level 3.1)
- Medium Intensity Residential Treatment - Adolescent (ASAM Level 3.5)
- Partial Hospitalization Program SUD (ASAM Level 2.5)
- Psychiatric Day Treatment
- Residential Treatment Services (RTS)
- Structured Outpatient Addiction Program (SOAP) (ASAM Level 2.1)
- Transitional Care Unit (TCU)
- Youth Stabilization Services (YSS)
- Functional Support Services
- Individualized Treatment and Recovery (ITS)+A65
- In-Home Therapy (IHT) - (CBHI)
- Intensive Community Based Acute Treatment (ICBAT)
- Intensive Outpatient Program (IOP)
- Low- Intensity Residential Treatment - Adolescent (ASAM Level 3.1)
- Medically Monitored Residential Withdrawal Management (ASAM Level 3.7)
- Partial Hospitalization - Eating Disorder
- Program for Assertive Community Based Treatment (PACT)
- Residential Rehabilitation Services (RRS) (ASAM Level 3.1)
- Specialty Residential Services for Pregnant and Parenting Women
- Therapeutic Mentoring (TM) - (CBHI)
- Youth Community Crisis Stabilization (YCCS)

### Outpatient

- Acupuncture Treatment
- Applied Behavioral Analysis (ABA)
- Assessment for Safe and Appropriate Placement (ASAP)
- Collateral Contact
- Diagnostic Evaluation
- Early Intervention Behavioral Intervention (EIBI)
- Family Consultation
- Individual Treatment
- Intensive In Home Services for Youth
- Medication Visit
- Narcotic Treatment Administration / Counseling
- NMNC 6.603.05 Psychiatric Visiting Nurse (Home Health Services)
- Opioid Treatment Program
- Outpatient Walk-In / Open Access
- Preventative Behavioral Health Services
- Psychological Testing
- Recovery Support Navigator (RSN)
- Ambulatory Withdrawal Management (Level 2WM)
- ASAP-Fire Setting
- Case Consultation
- Couples / Family Treatment
- Dialectical Behavioral Therapy (DBT)
- Electro-Convulsive Therapy (ECT)
- Group Treatment
- Inpatient-Outpatient Bridge Visit
- Medication Assisted Treatment / Medication Management (MAT)
- Methadone Counseling - Family / Group
- Neuropsychological Testing
- Office-Based Addiction Program (OBAT)/Office-Based Opioid Treatment Programs (OBOT)
- Outpatient Mental Health and Substance Abuse
- Peer Recovery Support
- Psychiatric Consultation on an Inpatient Medical Unit
- Recovery Coach
- Repetitive Transcranial Magnetic Stimulation (rTMS)

### Provider Types:

- Addiction Medicine (MD, DO)
- Certified Alcohol Counselor (CAC)
- Certified Alcoholism/Drug Abuse Counselor II (CADAC II)
- Licensed Alcohol and Drug Counselor I (LADC I, MLADC)
- Licensed Applied Behavior Analyst (LABA)
- Licensed Clinical Professional Counselor (LCPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Master Level Marriage and Family Therapist (MFT)
- Nurse Practitioner, Behavioral Health (APRN)
- Psychiatric Mental Health Nurse Practitioner (Psych NP)
- Psychiatrist-Child & Adolescent (MD, DO)
- Applied Behavioral Analysis (BCBA)
- Certified Alcoholism/Drug Abuse Counselor (CADAC)
- Licensed Alcohol and Drug Counselor (LADC)
- Licensed Alcohol and Drug Counselor II (LADC II)
- Licensed Clinical Mental Health Counselor (LCMHC)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Mental Health Counselor (LMHC)
- Master Level Clinician (MA, MS, MEd)
- Master Level Social Worker (LCSW, MSW)
- Physician Assistant, Behavioral Health (PA)
- Psychiatrist-Adult (MD, DO)
- Psychologist (PhD, PsyD, EdD)

### Crisis

- |                                                     |                                                     |
|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Crisis Intervention        | <input type="checkbox"/> Mobile Crisis Intervention |
| <input type="checkbox"/> Youth Crisis Stabilization |                                                     |

### Accessibility to Services

- |                                                                                              |                                                   |
|----------------------------------------------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Adults with Severe Physical Disabilities                            | <input type="checkbox"/> American Sign Language   |
| <input type="checkbox"/> Autism Services                                                     | <input type="checkbox"/> Children and Adolescents |
| <input type="checkbox"/> Children in the Care or Custody of DCF or Youth Affiliated with DYS | <input type="checkbox"/> HIV/AIDS Patients        |
| <input type="checkbox"/> Homeless Patients                                                   | <input type="checkbox"/> Visually Impaired        |

### 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?    |

### 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.

- |                                   |                              |                                                                                                                                                                                 |
|-----------------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>State license and Pending renewal documents</b><br>License Number: _____ Expiration Date: _____                                                                              |
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>Federally Required Disclosures form</b> (Required for MassHealth networks only)                                                                                              |
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>Professional Liability Insurance Policy Face Sheet</b><br>Policy Number: _____<br>Issue Date: _____ Per Incident \$: _____<br>Expiration Date: _____ Per Aggregate \$: _____ |
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>Drug Enforcement Agency (DEA) Certificate</b><br>DEA Number: _____ Expiration Date: _____                                                                                    |
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>Clinical Laboratory Improvement Amendments (CLIA) certificate</b><br>CLIA ID: _____ Expiration Date: _____                                                                   |
| <input type="checkbox"/> Attached | <input type="checkbox"/> N/A | <b>Letter / Certificate from National Accreditation Organization</b><br>Org Name: _____<br>Issue Date: _____ Expiration Date: _____                                             |

**Copy of most recent CMS or Department of Health survey report**

<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	Survey Date: _____
<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	<b>Corrective Action Plan (if survey resulted in 5 or more deficiencies)</b>
<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	<b>Complaint surveys, if applicable</b>
<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	<b>Evidence of Medicare enrollment, if applicable</b>
<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	<b>Evidence of Medicaid enrollment, if applicable</b>
<input type="checkbox"/> Attached	<input type="checkbox"/> N/A	<b>Current W-9</b>

**Attestation Questionnaire**

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

<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has this facility, under any current or former name or business entity, ever had its accreditation revoked or suspended?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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.***