

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

This is a supplemental data form. Please submit with a completed HCAS Provider Enrollment Form.
To ensure accurate record set-up, complete one form per NPI.

Provider Information		
Name & Degree:		NPI:
Specialty(ies):		
Provider Type: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based		
Currently participating in Medicare?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicare Number:
Currently participating in Medicaid?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid Number: State:
Include in our Provider Directory?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Provider's Race (Optional*): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to answer		
Provider's Ethnicity (Optional*): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Some other race <input type="checkbox"/> Declined to answer		
Provider Languages (Optional*): <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:		

** Race, ethnicity, and language information is optional and will be displayed in the Plan's provider directory if disclosed. WellSense does not discriminate or base credentialing decisions on this information.*

Group Information	
Group Name:	
Group NPI:	Group Tax ID:
Primary Office Location:	
Additional Addresses: See below.	
Mailing Contact Name:	Mailing Contact Title:
Mailing Contact Email:	Mailing Contact Phone:

Accessibility
Genders Served: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer, nonbinary, neither exclusively male nor female <input type="checkbox"/> Transgender male/trans man/female-to-male (FTM) <input type="checkbox"/> Transgender female/trans woman/male-to-female (MTF)
<i>*Not required to complete this section unless you wish to be on record for specializing in the treatment of specific genders and gender identities.</i>

Ages Treated: Do you wish to highlight to patients that you concentrate in serving members of a specific age group/population? Yes No

- Older Adults (Ages 65 and older)
- Middle-Aged Adults (Ages 45-64)
- Adults (Ages 25-44)
- Young Adults (Ages 19-24)
- Adolescents (Ages 13-18)
- Older Children (Ages 6-12)
- Younger Children (Ages 2-5)
- Infants (Ages 0-23 months)

**Not required to complete this section unless you wish to be on record for specializing in the treatment of specific ages.*

Acceptance Availability:

Are you accepting new patients? Yes No

Are you currently seeing established patients only? Yes No

Staff Languages:

- 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

Additional Office Locations: (include full location address)

Location 1: _____

- at least once per week
- at least once per month
- as a cover/fill-in as needed

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

Location 2: _____

- at least once per week
- at least once per month
- as a cover/fill-in as needed

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

Areas of Expertise

- | | | |
|---|---|---|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Adults with Severe Physical Disabilities | <input type="checkbox"/> Autism Services |
| <input type="checkbox"/> Bilingual or Multi-Lingual Abilities | <input type="checkbox"/> Children and Adolescents | <input type="checkbox"/> Children with Severe Physical Disabilities |
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> Geriatric Patients (65+) | <input type="checkbox"/> HIV / AIDS Patients |
| <input type="checkbox"/> Homeless Patients | <input type="checkbox"/> Indian Health Services | <input type="checkbox"/> Medication Assisted Treatment |
| <input type="checkbox"/> Private Duty Nursing | <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Concierge Services |
| <input type="checkbox"/> Translation Services | | |

Handicapped Accessibility

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

Special Populations Served (Optional*)

Do you wish to highlight to patients that you concentrate in serving members of certain special populations?
 Yes No

Race/Ethnicity

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> African | <input type="checkbox"/> African American | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> American | <input type="checkbox"/> Armenian | <input type="checkbox"/> Brazilian |
| <input type="checkbox"/> Cambodian/Khmer | <input type="checkbox"/> Canadian | <input type="checkbox"/> Cape Verdean |
| <input type="checkbox"/> Caribbean Islander | <input type="checkbox"/> Chinese | <input type="checkbox"/> Colombian |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Dominican | <input type="checkbox"/> English |

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> Filipino | <input type="checkbox"/> French | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Guatemalan | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Honduran | <input type="checkbox"/> Indian/Asian Indian | <input type="checkbox"/> Irish |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Laotian | <input type="checkbox"/> Mexican/Mexican American | <input type="checkbox"/> Chicano |
| <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Portuguese | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Salvadoran | <input type="checkbox"/> Scottish | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Ukrainian | <input type="checkbox"/> Vietnamese | |

Sexual Orientation

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Asexual | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Gay or Lesbian |
| <input type="checkbox"/> Straight or heterosexual | <input type="checkbox"/> Queer | |

Disability

- | | | |
|---|--|--|
| <input type="checkbox"/> Blind or Low Vision | <input type="checkbox"/> Deaf | <input type="checkbox"/> Hard of Hearing |
| <input type="checkbox"/> Developmentally disabled | <input type="checkbox"/> Intellectually disabled | |

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? |

Next Steps

Submit the following documents using the contact information provided at the top of this form

- Provider Data Form
- List of additional service locations if applicable
- HCAS Provider Enrollment Form
- Participating Provider Agreement (if not contracted)
- W-9 Form

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