# Provider Data Form

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

Completed form AND W-9 should be emailed to Provider.ProcessingCenter@wellsense.org or faxed to 617-897-0818.

| Provider Demographics (To be displayed in Provider Directory) | | |
|---|---|---|
| Provider Name: | ☐ PCP<br>☐ Hospital Based<br>☐ Specialist<br>☐ Locum Tenen*<br>* Complete Locum Tenen Credentialing Form | |
| Provider Title: | | |
| Mailing Contact Name: | Mailing Contact E-mail: | |
| Mailing Phone Number: | | |
| NPI: | Tax ID: | |
| Is this provider currently participating in Medicare? ☐ Yes ☐ No | Medicare Number: | Medicare State: |
| Is this provider currently participating in Medicaid? ☐ Yes ☐ No | Medicaid Number: | Medicaid State: |
| Primary Hospital Affiliation Name: | | |
| Effective Date of Privileges: | Category of Privileges: | |
| Community Health Center Name: | ☐ Community Health Center | |

| | |
|---|---|
| | ☐ Rural Health Center<br>☐ Federally Qualified Health Center |

Collaborating MD (include for PAs and NPs)

| Is provider a PCP? ☐ Yes ☐ No | Panel Open? ☐ Yes ☐ No | Established Patients Only? ☐ Yes ☐ No |
|---|---|---|
| | | |

**Please complete the section below to indicate whether the provider will serve the special populations listed below. Please note: The Commonwealth of Massachusetts requires us to collect this information.**

## Accessibility

Language Capabilities:

☐ Spanish ☐ Portuguese ☐ Haitian-Creole ☐ Vietnamese ☐ Russian

☐ Cambodian (Khmer) ☐ Chinese (Cantonese and Mandarin) ☐ Other: ___________________

Genders Served: ☐ Male ☐ Female Patient Ages Treated: ☐ 0-21 ☐ 22-65 ☐ 66 and over

Hours of Operation:

| Day | Start | End |
|---|---|---|
| Monday | Start: | End: |
| Tuesday | Start: | End: |
| Wednesday | Start: | End: |
| Thursday | Start: | End: |
| Friday | Start: | End: |
| Saturday | Start: | End: |
| Sunday | Start: | End: |

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

| | | |
|---|---|---|
| ☐ Accessible Examination Table | ☐ Accessible Restrooms | ☐ Accessible Scales |
| ☐ Bariatric Examination Tables | ☐ Bariatric Scale | ☐ Elevators in Multistory Buildings |
| ☐ Handicap Parking | ☐ Lifts (e.g. Hoyer) | ☐ Accessible via Public Transportation |
| ☐ Signs in Braille | ☐ TTY for Patient Services | ☐ Wheelchair Ramps |

## Other

**Please answer all of the questions by checking the appropriate “Yes” or “No” box.**

| ***YES*** | ***NO*** | |
|---|---|---|
| ☐ | ☐ | Are you a minority owned business? If yes, please provide a copy of your certification with this data form. |
| ☐ | ☐ | Are you a Woman owned business enterprise? If yes, please provide a copy of your certification with this data form. |
| ☐ | ☐ | Are you a Veteran owned business enterprise? If yes, please provide a copy of your certification with this data form. |
| ☐ | ☐ | Are you a LGBT owned business enterprise? If yes, please provide a copy of your certification with this data form. |

## Additional documents to submit to WellSense Health Plan

☐ Participating Provider Agreement (if not contracted)

☐ W-9 Form

☐ HCAS Enrollment Form (including covering physician information)

☐ Abbreviated Credentialing Form (Locum Tenen)

☐ Additional practice address and office hours if there are more service locations than listed on the HCAS Enrollment Form. Please attach an additional sheet if needed.

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

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