Provider Data Form - Medical

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

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: ☐ PCP ☐ Specialist ☐ Hospital Based	
Currently participating in Medicare?: ☐ Yes ☐ No	**Medicare Number:**
Currently participating in Medicaid?: ☐ Yes ☐ No	**Medicaid Number:** **State:**
Include in our Provider Directory?: ☐ Yes ☐ No	
Provider's Race *(Optional*)*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to answer	
Provider's Ethnicity *(Optional*)*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Some other race ☐ Declined to answer	
Provider Languages *(Optional*)*: ☐ Cambodian ☐ Chinese (Cantonese and Mandarin) ☐ Haitian-Creole ☐ Portuguese ☐ Russian ☐ Spanish ☐ Vietnamese (Khmer) ☐ 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:**
Additional Addresses: *Submit list of additional service locations beyond what is reflected the HCAS form, if applicable.*	
Mailing Contact Name:	**Mailing Contact Title:**
Mailing Contact Email:	**Mailing Contact Phone:**

Accessibility

Open Panel?: ☐ Yes ☐ No	**Genders Served:** ☐ Male ☐ Female
Established Patients Only?: ☐ Yes ☐ No	**Ages Treated:** ☐ 0-21 ☐ 22-65 ☐ 66 and over
Practice Language Services: ☐ 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:

Areas of Expertise

☐ 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

Handicapped Accessibility

☐ 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.*
- *If you answered "yes", please include a copy of your certificate.*

YES	***NO***	
☐	☐	Are you a minority owned business?
☐	☐	Are you a Woman owned business enterprise?
☐	☐	Are you a Veteran owned business enterprise?
☐	☐	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.