Senior Whole Health
BY MOLINA HEALTHCARE

Guide to Provider Forms

ACTION	YOU WILL NEED TO COMPLETE THE SECTIONS IDENTIFIED BELOW ON THE PROVIDER INFORMATION UPDATE FORM (PIF) AND ANY ADDITIONAL DOCUMENTS LISTED. ALL DOCUMENTS MUST BE COMPLETED AND RETURNED
Add a Provider to the group	• PIF – Complete Section A, Section N* and Section O * Section N can be copied when adding multiple providers • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) • Attachment B (Hospital Services) • CAQH (if applicable) **Submit these changes** to SWHCredentialing@MolinaHealthCare.Com
Individual: Change or add a service location	• PIF – Complete Section A, Section H and Section O • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) • Attachment B (Hospital Services)
Change Phone/Fax	• PIF – Complete Section A, Section F and Section O
Change the Pay-To/ Billing Address	• PIF – Complete Section A and Section I • W-9 • Sample Claim Form (de-identified)
Group: Change or add a service location	• PIF – Complete Section A, Section G and Section O • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) • Attachment B (Hospital Services) • ADA Attestation Form

Add a new group to the same Tax Identification Number (TIN)	• PIF – Complete Section A • W-9 • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) • Attachment B (Hospital Services) • Sample Claim Form (de-identified)
Change Group Name Only	• PIF – Complete Section A and Section D • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) with new group name • Attachment B (Hospital Services) with new group name • Sample Claim Form (de-identified) • W-9
Change TIN only	• PIF – Complete Section A and Section B • W-9 • Sample Claim Form (de-indentified)
Individual Name Change	• PIF – Complete Section A and Section D • Attachment A (Primary Care Providers, Specialists and Ancillary Providers) • Attachment B (Hospital Services) • W-9
Terming a provider	• See Section J for instructions
Provider Directory Update	• PIF – Complete Section A and Section L
Panel Update	• PIF – Complete Section A and Section K
Hospital Affiliations Update	• PIF – Complete Section A and Section M
Group/Individual NPI or Medicaid ID Change/Addition	• PIF – Complete Section A and Section C

FORMS:	FORM USAGE:
Provider Information Update Form (PIF)	This form is used to communicate changes, deletions and additions regarding an existing participating provider to Molina Healthcare.
Attachment A	This form is used for all Primary Care Providers (PCPs), Specialists and Ancillary Providers.
Attachment B	This form is used for all hospitals and hospital services.
W-9	This document is issued by the U.S. Internal Revenue Service (IRS). Molina Healthcare uses it to update the TIN owner name, doing business as name, and Tax ID when received with a PIF.
ADA Attestation Form	Providers use this form to attest to their compliance with American Disabilities Act (ADA) requirements for each physical service location.
Owner Disclosure Form	This form is used for all Provider Types when opening a new practice or change of ownership.
CAQH Form	This form is used for solo/groups at initial credentialing.
Credentialing - Individual Providers to Existing Group	**YOU WILL NEED TO...**
If you have a CAQH number	Complete CAQH Provider Data Form. You also need to update and give Molina Healthcare permission to review. Visit the website at http://www.caqh.org
If you do not have a CAQH number	Go to http://www.caqh.org to request a CAQH number and fill out the information. You will need to give permission to Molina Healthcare to review.
Credentialing - Facilities and Other Providers	**YOU WILL NEED TO ...**
Including Hospitals, Ambulatory Surgical Centers, Home Health Agencies, Durable Medical Equipment (DME) Suppliers, SNFs, Urgent Care Centers, and Retail Clinics	Please reach out to SWHCredentialing@MolinahealthCare.Com to request a Facility Application. This is for adding new locations to an existing participating Facility Agreement.
New Provider Requesting to Join our Network	**YOU WILL NEED TO ...**

For all Provider Types	For New Providers please fill out the Provider Contract Request Form Senior Whole Health of Massachusetts, Inc. 1075 Main Street, Suite 400 Waltham, Massachusetts 02451 Email: SWHNetworkRequests@MolinaHealthCare.com *Please note, if you are a current credentialed SWH Provider and looking to start your own practice, you will need to complete the Provider Contract Request Form.*
CONTACT INFORMATION	If you have additional questions, please contact Molina Healthcare's Provider Services department at (855)-838-7999 between the hours of 8 a.m. to 5 p.m. EST, Monday through Friday.

Senior Whole Health
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Provider Information Update Form (PIF)

Submission Date _____/_____/_____

This form and the associated documentation are required to notify Senior Whole Health any changes to your group/practice information and/or to begin the credentialing process. This form is also available at **https://www.molinahealthcare.com/providers/ma/swh/resources/forms.aspx**

Type of Group/Provider (Select all that apply):

☐ PCP ☐ Specialist ☐ Dental ☐ BH - Private Practice ☐ BH - CMHC/SUD

☐ Ancillary ☐ LTSS ☐ FQHC/RHC ☐ QFPP/Title X ☐ Urgent Care ☐ Hospital

CMHC/SUD Agencies Only: For any entity/organization-level updates, please use this form. All updates to employed rendering providers at a CMHC/SUD must be made through the Massachusetts Department of Medicaid/MassHealth System.

All Providers: If changing your Group/Practice Name and Tax ID Number, an Amendment is required. If changing the Group/Practice Name and Tax ID due to an ownership change, a new contract may be required. If you have any questions, please reach out to SWHNetworkRequests@MolinaHealthCare.Com

SECTION A

Practice Information (All fields in this section are required)

Practice Name: _____

Provider Name (if individual): _____

Practice Tax ID:_____ Practice Medicaid #:_____

Practice NPI #:_____ Practice Medicare #:_____

Contact Name: _____ Contact Number: _____

Email Address: _____

Tax Exempt ☐ Yes ☐ No

Return to first page.

SECTION B

Effective Date _____/ _____/_____

Tax ID Number Change/Addition

☐ Group TIN ☐ Individual TIN ☐ Facility TIN

Previous Tax ID Number: _____ New Tax ID Number: _____

Is this TAX ID Change being a result in new Ownership change? ☐ Yes ☐ No

If so, please complete the New Owner & Disclosure Form (link here) and attach a new W-9.

If you are leaving a group and starting another practice or joining a new practice/group and want to be contacted to discuss contracting at your new location, please reach out to SWHNetworkRequests@MolinaHealthCare.Com. Until you sign a new agreement, the new tax ID number and location are considered out of network.

Return to first page.

SECTION C

Group/Individual NPI or Medicaid ID Change/Addition Effective Date _____/_____/_____

☐ **Group NPI** ☐ **Individual NPI**

(If adding an NPI, do not fill out "Previous NPI" line.)

Group/Individual Name: _____

Previous NPI: _____

New NPI: _____

☐ **Group Medicaid ID** ☐ **Individual Medicaid ID**

(If adding a Medicaid ID, do not fill out "Previous Medicaid ID" line.)

Previous Medicaid ID: _____

New Medcaid ID: _____

Return to first page.

SECTION D

Practice Name Change Effective Date _____/_____/_____

☐ Individual ☐ Group ☐ Facility/Hospital ☐ (others) _____

Previous Practice Name: _____

Medicaid #: _____ Medicare #: _____

Current/New Practice Name: _____

Medicaid #: _____ Medicare #: _____

Reason: (Required) _____

Is this a result of a new Ownership change? ☐ Yes ☐ No

If yes, please complete the New Owner & Disclosure Form (link here) and attached a new W-9.

Please email supporting documentation to: SWHNetworkRequests@MolinaHealthCare.Com.

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SECTION E

Change Phone/Fax Effective Date _____/_____/_____

☐ Adding additional Phone/Fax Number

☐ Replacing Phone/Fax Number

Previous Phone Number: _____ New Phone Number: _____

Previous Fax Number: _____ New Fax Number: _____

Address: _____ City, State, Zip: _____

Return to first page.

Section G (Group)

☐ **Adding a Service Location** Effective Date _____/_____/_____
☐ **Removing a Service location**

Is location closing: Y ☐ N ☐
Please complete the ADA Attestation Form for all new Service Locations.

Previous Address	**New Address**
Service Location Name:_____	Service Location Name:_____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

Return to first page.

Section H (Individual)

☐ **Adding a Service Location** Effective Date _____/_____/_____

☐ **Removing a Service location**

Previous Address	**New Address**
Service Location Name: _____	Service Location Name:_____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Email: _____	Email: _____

Are you leaving the current practice? ☐ Yes ☐ No
Are you starting your own practice? ☐ Yes ☐ No

If yes, please complete the Provider Contract Request Form and submit all the necessary supporting documentations to SWHNetworkRequests@MolinaHealthCare.Com

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SECTION I

Billing Address Change Effective Date _____/_____/_____

Previous Billing Information	New Billing Information
Billing Contact: _____	Billing Contact: _____
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City, State, Zip: _____	City, State, Zip: _____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____

- Is this a Notice Address Change? ☐ No ☐ Yes

The Notice Address is the particular party's address for delivery or mailing of notice purposes.

Return to first page.

SECTION J

Terminating a Provider

A termination letter is required on **company letterhead** and must include the following: Practice Name, Billing Tax ID, Billing NPI, name of the provider to be termed, effective date of termination, reason for termination and address of practice location(s). If terming provider is a PCP, include name of provider that will assume patient panel.

Please submit the **Termination Letter** to PR: *SWHProviderRelations@MolinaHealthCare.Com*

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SECTION K

Panel Update

☐ Accepting Only Existing Patients
☐ Close Panel to all Members
☐ Open Panel

Effective Date _____/_____/_____

Reason: (Required) _____

☐ *If temporarily, please provide resume date* _____

Return to first page.

SECTION L

Provider Directory Update

Effective Date _____/_____/_____

☐ Include in Provider Directory
☐ Exclude from Provider Directory

Reason: (Required) _____

Return to first page.

SECTION M

Hospital Affiliations Update Effective Date _____/_____/_____

☐ Add Hospital Affiliation(s) ☐ Remove Hospital Affiliation(s)

Names of Hospital(s): _____

Address: _____

Return to first page.

SECTION N

Provider Joining a Group/Practice Effective Date _____/_____/_____ Locum Tenen: ☐ Y ☐ N

Provider Name (Last, First, MI):_____

Provider Type (MD, DO, DC, DDS, DPM, etc): _____ Date of Birth: _____

Last Four Digits of Social Security #: _____ Provider Ethnicity:

☐ African American ☐ Caucasian

☐ Asian/Pacific Islander ☐ Hispanic

☐ Alaskan/American Indian ☐ Other

Individual Provider NPI Number: _____ CAQH Provider Number: _____

For Nurse Practioners, Physician Assistants and Nurse Midwives only:	Supervising Physician Name & Degree	Supervising Physician Specialty:

Note: Please ensure the provider has completed and/or re-attested to the CAQH Application and authorized Molina Healthcare to access CAQH.

MA Medicaid Number: _____ **MA Medicare Number:** _____

(Provider must have an active Medicaid Number)

Specialty _____ **Secondary Specialty:** _____

Applying as: ☐ PCP ☐ Specialist ☐ Hospitalist ☐ Other

For Behavioral Health Providers: Are you individually accessible by appointment? ☐ Yes ☐ No

Board Certified: ☐ Yes ☐ No Effective Date _____/_____/_____ Expiration Date _____/_____/_____

Certification Board: _____

Group/Practice Name: _____

Group/Practice Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Return to first page.

Section 0

Office Hours

	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Return to first page.

If you have any questions, visit our website at https://www.molinahealthcare.com/providers/ma/swh/home.aspx or call Provider Services at (855)-838-7999. Representatives are available to assist you Monday through Friday from 8 a.m. to 5 p.m.

Please email this form and supporting documentation to:

SWHProviderRelations@MolinaHealthCare.Com

For New Providers Joining a Group follow the add a provider to group action and email completed sections to:

SWHCredentialing@MolinaHealthCare.Com

For any TIN, Name Change, or Ownership change, please complete the appropriate section and email the form and supporting documentation to:

SWHNetworkRequests@MolinaHealthCare.Com

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Massachusetts Department of Medicaid

MANAGED CARE ENTITY (MCE) – GROUP PROVIDER AFFILIATIONS – ATTACHMENT A

Provider Group Name	**MCE Name** Senior Whole Health by Molina Healthcare
Group Tax ID Number	**Group NPI***
Group Medicaid ID*	**Provider Signature**

***Please submit a separate Attachment A for any given Group/Location NPI and/or Group Medicaid ID.**

(Groups should provide Group name, NPI and Tax ID Number above and individual practitioner NPI under "Provider NPI" below.)
(Ancillary providers are not required to list employees on this attachment. Ancillary, Urgent Care, FQHC and RHC providers: List each service location.)

Last	First	MI	Spec	Service Location (Name and Street Address)	Medicaid ID	Y or N	Provider NPI	Capacity (PCP only)

MCE acknowledges changes on the date received. Effective Date will be determined by the MCE. Each rendering provider's name must be listed. "Capacity" represents the maximum number of the MCE's Medicaid members primary care providers (PCP) agree to serve. For Yes or No, Provider must be in practice for 2 plus years and have treated members age 65 plus. Please indicate a numeric capacity value instead of "unlimited" or similar response. For any given PCP, total capacity must not exceed 2,000 across all locations. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3). Provider signature indicates information is accurate and up to date.

Send this attachment for new providers joining a group to SWHCredentialing@MolinaHealthCare.Com

Return to first page.

MANAGED CARE ENTITY (MCE) – HOSPITAL SERVICES ATTACHMENT B

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page *(e.g., 1 of 3, 2 of 3, and 3 of 3)* and the signature block must be included on each page. MCE acknowledges changes on the date received. Effective Date will be determined by the MCE.

Senior Whole Healthcare by Molina Healthcare

Hospital Information

Hospital Name				
Address	City	State	Zip	County
Tax ID Number	NPI	Secondary NPI		

1. Hospital Services Categories

Please check the applicable line for each category of service the above-named hospital covers.

☐ Surgical Services	☐ Neonatal Intensive Care - Level 3	☐ Special Care
☐ Pediatric Surgical Services	☐ Adult Intensive Care	☐ Outpatient Psychiatric Services
☐ Obstetrical Services	☐ Midwife Services	☐ Practitioner Services
☐ Nursery Services	☐ Outpatient Surgery	☐ Other *(Please specify)*
☐ Nursery Services Level 1 & 2	☐ Pediatric Intensive Care	

2. Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds. List services:

Return to first page.

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Please complete the following attestation for each provider service location and return it with your signed contract:

Provider Name: _____ **Tax ID #or SSN:** _____

Address: _____ **Phone:** _____

Email Address: _____

The American with Disabilities Act (ADA) and SWH MA Administrative Code require providers make reasonable access and accommodations for all persons with disabilities. Molina is providing you with the opportunity to self-attest to the below ADA standards in order to verify core elements of ADA compliance for the SWH MA Program.

If you are not an office-based provider, please check here and proceed to the signature section below: ☐

If you are an office-based provider, please check the applicable box next to each standard below and have the designated representative sign and return the attestation to Molina Healthcare.

ADA STANDARDS	YES	NO
Building has handicap designated parking. Parking spaces are accessible with ramps and curb cutouts between the parking lot, office, and at drop off locations.		
Building has automatic entry option or alternative access method.		
Building has elevator for public use (if building is multi-leveled). Elevator has enough room for the wheelchair and/or scooter to maneuver.		
Restroom is equipped with large stall and safety bars or other reasonable accommodations.		
Waiting room (including furniture) can accommodate patients with physical and non-physical disabilities. The reception and waiting areas have enough room for a wheelchair and/or scooter to maneuver and turn around.		
At least one exam room can accommodate patients with physical and non-physical disabilities.		
Signage and way finding is clear (e.g. color, symbol signage, and braille).		
Doors to access building, office, and patient rooms are at least 32 inches wide.		
The exam table moves up and down to make it easier to get on and off whether standing or using a wheelchair or scooter.		
Diagnostic equipment can accommodate patients with disabilities.		
The scale is able to accommodate a wheelchair or scooter.		

Provider service locations that attest to being ADA compliant or have received an in-office assessment and determined to be ADA compliant will be published as such in the Senior Whole Health Provider Directory.

I attest to the best of my knowledge that the above information is true, accurate and complete.

Name: _____ Signature: _____

Title: _____ Date: _____

If you have any questions or concerns, please contact Molina Healthcare Provider Relations at (855) 838-7999. Thank you for your prompt response.

Senior Whole Health of Massachusetts, Inc. 1075
Main Street, Suite 400
Waltham, MA 02451
SWHProviderRelations@MolinaHealthCare.Com

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FEDERALLY REQUIRED DISCLOSURES

INDIVIDUAL PRACTITIONERS

Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth

Print Clear

Please ensure that all sections of this form are completed before submission.

Federal law requires that individual practitioners providing or seeking to provide services to MassHealth members disclose certain information to MassHealth. See 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3. MassHealth requires the submission of tax identification numbers (TINs), e.g., social security numbers (SSNs) or employer identification numbers (EINs), for purposes necessary to properly administer the MassHealth program (see 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405(c)(1)). Unless otherwise instructed by MassHealth, individual practitioners must use this form when disclosing such information to MassHealth.

SECTION 1: PRACTITIONER INFORMATION

Legal Name of Practitioner: Last	First	Middle Initial
Date of Birth	National Provider Identifier Number (NPI)	SSN
Home Street Address		
City	State	Zip –
Tel. # – –	Fax # – –	
E-mail		
Preferred Contact Name (if different than above)		
Preferred Contact E-mail (if different than above)		
Tel. # – –		

SECTION 2: PRIMARY SERVICE LOCATION (PSL) INFORMATION

DBA Name (Primarily applies to individuals who are sole proprietors and NOT to entities separately completing PE-FRD)
☐ NONE

Is PSL address same as home address in Section 1? ☐ Yes ☐ No. If yes, practitioner need not complete remainder of Section 2.

PSL Street Address (street address only; P.O. Boxes are not acceptable)		
City	State	Zip –
Tel. # – –	Fax # – –	
E-mail		

SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the applicant;
ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the applicant or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the applicant;
iii. Is an officer or director of the applicant, if the applicant is organized as a corporation;
iv. Is partner in the applicant, if the applicant is organized as a partnership;
v. Is an agent of the applicant;
vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the applicant or part thereof, or directly or indirectly conducts the day-to-day operations of the applicant or part thereof; or
vii. Was formerly described in i through vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

The definitions applicable to this section are as follows:

- *Agent* means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice organization).
- *Immediate family member* means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- *Indirect ownership interest* includes an ownership interest through any other entities that ultimately have an ownership interest in the applicant (e.g., an individual has a 10 percent ownership interest in the applicant if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the applicant).
- *Member of household* means, with respect to a person, any individual with whom he or she is sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.
- *Ownership interest* means an interest in:
  - the capital, the stock, or the profits of the applicant; or
  - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the applicant.

☐ NONE (if NONE continue to Section 4) ☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity																			
NPI										% of Ownership (if 5% or more)									
Title, Function, or Relationship to Practitioner																			
Address (Home Address if Individual; Business Address if Entity)																			
City							State			Zip						–			
SSN (if Individual)						Date of Birth						EIN (if Entity)							

*For definition and further explanation of these terms, please see the top of Section 3 above.

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE THAN THREE INDIVIDUALS OR ENTITIES OR ADDITIONAL ADDRESSES. **NUMBER** ☐ **OF** ☐
(All business, corporate, and P.O. boxes must be listed.)
Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity

NPI | % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City | State | Zip | –

SSN (if Individual) | Date of Birth | EIN (if Entity)

☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity

NPI | % of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City | State | Zip | –

SSN (if Individual) | Date of Birth | EIN (if Entity)

* For definition and further explanation of these terms, please see the top of Section 3 above.

SECTION 4: DISCLOSURES

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

4A. DISCLOSURE INFORMATION

Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer "yes" to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?
☐ Yes ☐ No

2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?
☐ Yes ☐ No

3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?
☐ Yes ☐ No

4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
☐ Yes ☐ No

5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?
☐ Yes ☐ No

6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 5, above?
☐ Yes ☐ No

4B. ADDITIONAL EXPLANATION

If you answered "yes" to any question in Section 4A, you must provide a detailed explanation below, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 5: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Printed Legal Name of Practitioner | Signature | Date

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the practitioner are not acceptable.

Print Clear

Return your completed form to providersupport@mahealth.net or mail to the following:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 121205
Boston MA 02112-1205

If you have questions about or need assistance with the completion of this form, please e-mail the MassHealth Customer Service Center at providersupport@mahealth.net or call 1-800-841-2900.