



# MassHealth Nonbilling Provider Contract for Individuals

This Nonbilling Provider Contract (this “Contract”) is between the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (hereinafter MassHealth), and

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(Legal Name of Nonbilling Provider, hereinafter the “Nonbilling Provider”)

In consideration of the mutual promises contained herein, the parties agree as follows.

## **I. The Nonbilling Provider agrees:**

- A. and understands that he or she is enrolling in MassHealth as a nonbilling provider because his or her National Provider Identifier (NPI) is or may be included on claims submitted by a MassHealth-participating billing provider;
- B. and understands that he or she may order, refer, prescribe, provide, or supervise the ordering, referring, prescribing, or provision of services to MassHealth members within the scope of his or her licensure, but shall not submit claims to or receive payments from MassHealth;
- C. to comply with all state and federal statutes, rules, and regulations applicable to the nonbilling provider’s participation in MassHealth;
- D. to order, refer, prescribe, or provide services to eligible members without regard to religion, race, color, or national origin in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq. and its implementing regulations at 45 CFR Part 80), and without regard to disability in compliance with Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794 and its implementing regulations at 45 CFR Part 84), and without regard to age in compliance with Section 6102 of the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq. and its implementing regulations at 45 CFR Part 90.1 et seq. and 45 CFR Part 617);
- E. to keep such records as are necessary to disclose fully the extent and medical necessity of the services that the nonbilling provider orders, refers, prescribes, or provides to MassHealth members and to preserve these records for at least six years, or for such a length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer;
- F. to furnish MassHealth, the United States Secretary of Health and Human Services, the Attorney General’s Medicaid Fraud Division, the State Auditor, and any other state and federal agency to which disclosure is required by law, upon request, with such information, including copies of medical records, about any services that the nonbilling provider orders, refers, prescribes, or provides to MassHealth members;
- G. to comply with the federal disclosure requirements specified in 42 CFR Part 455, Subpart B;
- H. to furnish to MassHealth the nonbilling provider’s national provider identifier (NPI), and include such NPI on all orders, referrals, and prescriptions for MassHealth members;
- I. to permit the federal Centers for Medicare & Medicaid Services and the MassHealth agency, and their agents and designated contractors, to conduct unannounced onsite inspections of any and all provider locations for the limited purpose of investigating suspected fraud or abuse related to MassHealth; and
- J. to notify MassHealth within 14 days of any changes in the information submitted on his or her application.

**II. The Nonbilling Provider and MassHealth mutually agree:**

- A. that any Special Conditions that indicate they are to be incorporated into this Contract and that are signed by both parties to this Contract will be deemed to be part of this Contract and that in the event of any inconsistency between the Special Conditions and this Contract, the former shall control; and
- B. that this Contract shall take effect upon notification of acceptance by MassHealth and shall continue in effect until terminated by either party upon written notice to the other party; and that MassHealth may not terminate this Contract without affording to the nonbilling provider any applicable right to contest such termination available under federal and state law and regulation that has been properly requested by the provider.

NONBILLING PROVIDER

\_\_\_\_\_  
(Legal Name of Nonbilling Provider)

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_  
(Printed Name)

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Do not write below this line.

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EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

*Executive Office of Health and Human Service*

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_  
(Printed Name)

Title: \_\_\_\_\_ Date: \_\_\_\_\_

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

**CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS APPLICATION (MassHealth may contact you if there are questions about this application.)**

Name	Tel. #				-															
Email																				

This form is used to enroll providers who do not submit claims to or receive payment from MassHealth, but whose National Provider Identifier (NPI) is included on claims submitted by billing providers.

All providers whose NPI must be included on claims due to any state or federal requirement, such as the ordering and referring requirement referenced below, HIPAA 5010, or other requirements, and providers whose NPI is included on a claim by a billing provider for other reasons, must be enrolled with MassHealth at least as a nonbilling provider.

For example, if MassHealth requires a service to be ordered, referred, or prescribed by any of the provider types listed in Section 1 of this form, then federal law requires that:

1. the ordering, referring, or prescribing provider's NPI must be included on the billing provider's claim; and
2. the ordering, referring, or prescribing provider be enrolled with MassHealth at least as a nonbilling provider.

This requirement applies to independent providers as well as facility-based providers. In addition, when a clinician not listed in Section 1 below orders or refers a service, then the NPI of a provider listed in Section 1, such as the supervising physician's NPI, must be included on the claim. In that situation, the physician would also need to enroll as a nonbilling provider.

Note, however, that this form should not be used for providers who work in a group practice, since those providers must be fully enrolled with MassHealth.

Please also note that there is also a separate nonbilling provider application for pharmacists who are authorized to prescribe. Please call customer service at the number listed below to request the pharmacist application if you qualify as a pharmacist who is authorized to prescribe.

Providers enrolled in MassHealth through this form are not permitted to submit claims to or receive payment from MassHealth. Providers who are in a category that MassHealth recognizes as billing providers, and who wish to enroll in MassHealth as a billing provider, should contact the Customer Service Center (CSC) at 1-800-841-2900 to request an enrollment packet.

You should have already obtained an individual NPI from an NPI Enumerator. You should ensure that the Primary Practice Address registered with the NPI Enumerator reflects the street address entered in the Primary Service Location portion of this application associated with the organization with which you are affiliated. If you are authorized to prescribe medications, you are required to enter a Primary Taxonomy Code that indicates that you have the appropriate clinical discipline to write a prescription. Additionally, prescribers writing prescriptions for CII–CV medications are required to enter a DEA number.

If you are not fully licensed, and have limited license status, please attach a copy of your limited license to your application.

Please complete, sign, and return this form and the Nonbilling Provider Contract by mail to the MassHealth Customer Service Center, Attn: Provider Enrollment, P.O. Box 121205, Boston, MA 02112-1205. You can address questions about the form to CSC. Dentists should submit the form and signed contract by mail to DentaQuest at MassHealth Dental Program, Attn: Provider Enrollment and Credentialing, P.O. Box 2906, Milwaukee, WI 53201-2906. All information is subject to audit.

# SECTION 1: APPLICANT INFORMATION

Legal name of applicant	Applicant's date of birth
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Applicant's individual National Provider Identifier Number (NPI)
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Applicant's SSN	Primary Taxonomy Code*
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Provider type (Interns, residents, and other trainees authorized to order, refer, or prescribe services should check the relevant provider type below and submit a copy of their limited license with this application.)

<input type="checkbox"/> PT 01: Physician	<input type="checkbox"/> PT 08: Certified nurse midwife	<input type="checkbox"/> PT 51: Certified registered nurse anesthetist
<input type="checkbox"/> PT 02: Optometrist	<input type="checkbox"/> PT 10: Dentist	<input type="checkbox"/> PT 57: Clinical nurse specialist
<input type="checkbox"/> PT 05: Psychologist	<input type="checkbox"/> PT 17: Nurse practitioner	<input type="checkbox"/> PT 78: Psychiatric clinical nurse specialist
<input type="checkbox"/> PT 06: Podiatrist	<input type="checkbox"/> PT 39: Physician assistant	<input type="checkbox"/> PT 92: Licensed independent clinical social worker

Applicant's primary Massachusetts DEA number** _____
<input type="checkbox"/> Check box if the DEA is that of the primary affiliated institution***
<input type="checkbox"/> Check box if prescribing only Schedule VI drugs
<input type="checkbox"/> Check box if in a provider type that is authorized to prescribe, but you are not prescribing

\* For providers who prescribe medications.  
 \*\* Note that, with the exception of providers prescribing only Schedule VI drugs, providers must have a DEA number in order to prescribe medications.  
 \*\*\* Providers authorized to prescribe under their affiliated hospital's DEA registration number should enter that institution's DEA number.

Applicant's out-of-state DEA number (if applicable):	For which state does the applicant have a DEA number?
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Applicant's Massachusetts license number
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Does the applicant hold a license from another state?	State		License number
State		License number	State

Home street address														
City								State		Zip		-		
Tel. #				-		-		Fax #		-		-		
Email														

Primary Service Location (PSL) (all applicants must complete this section if PSL is different than home address) street address (street address only; no P.O. Boxes are allowed)

City								State		Zip		-		
Tel. #				-		-		Fax #		-		-		
Email														

Preferred contact name															
Preferred contact Email									Tel. #		-		-		

Service Location name	Service Location MassHealth provider ID
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Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site?  Yes  No

If yes, is the applicant on staff and working as a primary care provider at this service location?  Yes  No

If yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology?  Yes  No

**Any applicant who is a primary care provider for MassHealth Primary Care Clinician (PCC) Plan members at additional community health center, acute hospital outpatient department, hospital-licensed health center, or Indian Health Service sites must complete a Service Location section for each such additional site.**

Service (SL) (if different than home address) street address (street address only; no P.O. Boxes are allowed)

City	State	Zip	-
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Tel. #	-	-	Fax #	-	-
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Email

Preferred contact name

Preferred contact Email	Tel. #	-	-
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Service Location name	Service Location MassHealth provider ID
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Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site?  Yes  No

If yes, is the applicant on staff and working as a primary care provider at this service location?  Yes  No

If yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology?  Yes  No

Service (SL) (if different than home address) street address (street address only; no P.O. Boxes are allowed)

City	State	Zip	-
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Tel. #	-	-	Fax #	-	-
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Email

Preferred contact name

Preferred contact Email	Tel. #	-	-
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Service Location name	Service Location MassHealth provider ID
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Is this service location a community health center, hospital outpatient clinic, hospital licensed health center, or Indian Health Service AND contracted with MassHealth as a PCC Plan site?  Yes  No

If yes, is the applicant on staff and working as a primary care provider at this service location?  Yes  No

If yes, is the applicant board certified or board eligible (or in the case of a nurse practitioner, does the applicant specialize) in any of the following: family practice, pediatrics, internal medicine, obstetrics, or gynecology?  Yes  No

If you need to list more service locations, please copy this page as needed and include it with your submitted application.

## SECTION 2: DISCLOSURES\*

### 2A. OWNERS, MANAGING EMPLOYEES, AND AGENTS OF APPLICANT

Disclose any individual or entity that meets at least one of the below criteria (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 a 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-
- vii. Was formerly described in 2.A.i through 2.A.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

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 applicant (e.g., office manager, billing agent).
- *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.

List any familial relationships (spouse, parent, child, sibling) to the applicant and/or any other disclosed individual described above. If additional space is needed, please copy this page and attach to application.

*Note: It is less common for applicants practicing solely as an employee of an organization to have relationships described in this section. It is more common for applicants who participate in a group practice or who have an office manager, billing agent, or similar staff, to have relationships described in this section.*

\* For additional information, see 42 CFR § 455.106, 42 CFR 455.436, and 42 CFR §1002.3.

NONE (if NONE continue to Section B)

Name of individual or entity  Has ownership or control\*\*  Managing employee\*\*  Agent\*\*

Percent of ownership (if applicable) | NPI (if applicable)

Title, function, or association to applicant

Address(es) (City, state, zip; home if individual/business, headquarters; and P.O. Boxes if entity)

SSN (if individual)/TIN (if entity) | Date of birth (if individual)

Familial relationship (if individual, if any)

\*\* For clarification and definition of the choices, please see the top of Section 2A above.

Name of individual or entity	<input type="checkbox"/> Has ownership or control**	<input type="checkbox"/> Managing employee**	<input type="checkbox"/> Agent**
Percent of ownership (if applicable)	NPI (if applicable)		
Title, function, or association to applicant			
Address(es) (City, state, zip; home if individual/business, headquarters; and P.O. Boxes if entity)			
SSN (if individual)/TIN (if entity)	Date of birth (if individual)		
Familial relationship (if individual, if any)			

\*\* For clarification and definition of the choices, please see the top of Section 2A above.

**2B. DISCLOSURES**

Respond to the following questions on behalf of the applicant AND any individuals/entities identified in Section 2.A. If you answer “yes” to any question, provide a detailed explanation in Section 2.C, including the name of the individual/entity; the nature, date, and forum of the action; and any case or record number.

Has 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

Has 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

Has 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

Has any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  YES  No

Has any of the individuals/entities ever been subject to disciplinary action by a licensing board in any state?  YES  No

**2C. ADDITIONAL EXPLANATION**

If you answered “yes” to any question in Section 2.B, you must provide a detailed explanation below, including the name of the individual/entity; the nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

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**SECTION 3: 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 Applicant

Signature

Date

Note: Signature stamps, date stamps, or the signature of anyone other than the applicant are not acceptable.