Revised 3/2025

HCAS HEALTHCARE ADMINISTRATIVE SOLUTIONS, INC.

HCAS Provider Enrollment Form

Important: Please go to CAQH to submit additional practice information necessary to comply with state & federal provider directory requirements.

Date	Completed By	Telephone	Email Of Person Completing Form

Section 1: Provider Information

Provider First Name	Middle Initial	Provider Last Name	Degree/Title	Social Security Number	Date of Birth	Gender
						M ☐ F ☐ Non-Binary ☐

Provider Email Address:		Languages spoken by provider:	
Specialty:	Board Certified? Yes ☐ No ☐	If you are not certified, are you eligible? Yes ☐ No ☐	If yes, Exam date:
Subspecialty:	Board Certified? Yes ☐ No ☐	If you are not certified, are you eligible? Yes ☐ No ☐	If yes, Exam date:

CAQH ID:	National Provider Identifier (NPI):	License #:	DEA #:

Provider Category: PCP ☐ Specialist ☐ Both ☐ Hospital Only ☐ Moonlighter/Covering ☐	Primary Hospital Affiliation & Staff Position:	Secondary Hospital Affiliation & Staff Position:	Other Affiliations:	If no hospital affiliation, provide admitting arrangements and MD name:

Nurse Practitioner Board Certificate Number: Provide collaborating MD for all NP's, PA's and APRN's:

Some emergency medicine, radiologists, anesthesiologists, or pathologists who practice exclusively within a facility and who do not receive direct referrals may qualify for an abbreviated process. Please check here if you meet the criteria. ☐

Section 2: Primary Practice Information

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group. Use last page to list additional addresses.

Practice Name:

Is this your Mailing Address? Yes ☐ No ☐ If no, complete last page.
Is this your Credentialing Address? Yes ☐ No ☐ If no, complete last page.

Can patients make an appointment at this location? Yes ☐ No ☐
If yes, include this address in health plan directories? Yes ☐ No ☐
If yes, do you offer both in person & telehealth/virtual visits? Yes ☐ No ☐
If no, do you offer Telehealth only services (no in person visits)? Yes ☐ No ☐

Primary Address:

Street			
City	State	Zip Code	Languages spoken by office staff:

Appointment Scheduling Telephone: FAX: Practice Email: Practice Manager Name: Practice Start Date:

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes ☐ No ☐

Handicap Access: Yes ☐ No ☐

Practice Type: Solo ☐ Partnership ☐ Single ☐ Specialty Group ☐ Multi-Specialty Group ☐ Concierge Model ☐ Other:

Does this office location use an Electronic Medical Record? Yes ☐ No ☐

Does this office offer E-prescribing? Yes ☐ No ☐

Section 3: Payment Information

Payee Name: _____ | _____

Tax Identification Number | Group NPI #

Payment Address _____

Street

_____ | _____ | _____ | _____

City | State | ZIP Code | Email

_____ | _____ | _____

Telephone | Fax | Contact Name

Section 4: Other Provider Information

What is the provider's status? Accepting new patients ☐ Accepting existing patients only ☐ Closed (not accepting new patients) ☐

What age groups does the provider treat?

Does the provider participate in and meet the conditions of participation in Medicare? Yes ☐ No ☐

Does the provider have a current, valid and active Medicare participating PTAN number? Yes ☐ No ☐

If yes, please indicate participating individual PTAN number:

Please indicate individual Medicaid number:

Does your organization make decisions to treat patients based solely on a patient's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient? Yes ☐ No ☐

Describe the steps you take to monitor for and prevent discriminatory practices:

Practitioner Rights Notification

Providers have the right to review information submitted on this form and to correct or update information by contacting a health plan(s) directly.

Additional Documents to Submit: Please see *Health Plan Contracting and Enrollment Required Documents List* located on the Credentialing Resources page at **www.hcasma.org**.

Section 5: Submission Information

Blue Cross Blue Shield of MA **Fax:** 617-246-4227 **Phone:** 800-316-BLUE (2583) **Email:** NetworkManagement@bcbsma.com	**Fallon Health** 1 Mercantile St., Suite 400 Worcester, MA 01608 **Fax:** 508-368-9902 **Provider Services:** 866-275-3247, prompt 4 **Email:** providerdataupdates@fallonhealth.org	**Harvard Pilgrim Health Care** Attn: Provider Processing Center **Fax:** 866-884-3843 **Email:** PPC@point32health.org
Health New England One Monarch Place, Suite 1500 Springfield, MA 01144 **Fax:** 413-233-3175 **Phone:** 800-842-4464 **Provider Contracting Email**: PContracting@HNE.com	**Mass General Brigham Health Plan** Credentialing Department 399 Revolution Drive, Suite 820 Somerville, MA 02145 **Provider Service Center:** **Fax:** 617-526-1982 **Phone:** 855-444-4647 **Email:** HealthPlanPEC@mgb.org	**Tufts Health Plan/Tufts Health Public Plans** Attn: Provider Enrollment 1 Wellness Way Canton, MA 02021 **Fax:** 617-972-9591 **Phone:** 617-972-9400 **Email:** Provider_Information_Dept@point32health.org
WellSense Health Plan Provider Processing Center 100 City Square, Suite 200 Charlestown, MA 02129 **Fax:** 617-897-0818 **Provider Processing Center:** 888-566-0008 **Email:** providerprocessingcenter@wellsense.org		

Additional Practice Location

Please check box to indicate address type. Please complete a separate page for all new enrollees in the group

Practice Name: _____

Additional Practice ☐ Mailing Address ☐ Credentialing Address ☐
Can patients make an appointment at this location? Yes ☐ No ☐
If yes, include this address in health plan directory? Yes ☐ No ☐
If yes, do you offer both in person & telehealth/virtual visits? Yes ☐ No ☐
If no, do you offer Telehealth only services (no in person visits)? Yes ☐ No ☐

Address:

Street

City | State | ZIP Code | Languages Spoken by office staff

Appointment Scheduling Telephone: Fax: Practice Email: Practice Manager Name: Practice Start Date:

Optional Practice Information

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Your Practice must provide 24-hour coverage. Do you have 24-hour coverage? Yes ☐ No ☐
Handicap Access: Yes ☐ No ☐
Practice Type: Solo ☐ Partnership ☐ Single ☐ Specialty Group ☐ Multi-Specialty Group ☐ Concierge Model ☐ Other: ☐
Does this office location use an Electronic Medical Record? Yes ☐ No ☐
Does this office offer E-prescribing? Yes ☐ No ☐