commonwealth care alliance

COMMONWEALTH CARE ALLIANCE (CCA) PROVIDER CONTRACT REQUEST/INITIATION FORM

Please complete all applicable sections of this form and return to CCAContracting@commonwealthcare.org

Organization/Practice Name:	
Legal Name:	
Tax ID:	**Organization NPI:**
Phone:	**Fax:**
Primary Address: *If you have additional locations, please attach site location list with form.*	

Counties Served (Please check all appropriate boxes for the area that you service):

☐ Barnstable	☐ Essex	☐ Middlesex	☐ Suffolk
☐ Berkshire	☐ Franklin	☐ Nantucket	☐ Worcester
☐ Bristol	☐ Hampden	☐ Norfolk	☐ Other (Please Explain):
☐ Dukes	☐ Hampshire	☐ Plymouth	

Provider Type/Specialty:

☐ Acute Care Hospital	☐ Long Term Acute Care Facility
☐ Adult Day Health	☐ Orthotics and Prosthetics
☐ Adult Foster Care	☐ Outpatient Behavioral Health
☐ Assisted Living	☐ Outpatient Dialysis
☐ Certified Home Health Agency	☐ Peer Support, Counseling, Navigation
☐ Day Habilitation	☐ Primary Care
☐ Day Services	☐ Rehabilitation Facility
☐ Durable Medical Equipment	☐ Skilled Nursing Facility
☐ Group Adult Foster Care	☐ Physician Specialty (please specify) _____
☐ Home Care Services	☐ Substance Abuse Treatment
☐ Hospice	☐ Vision Care
☐ Laboratory	☐ Other (please specify)_____

Please note any specific capabilities or services that set you apart from other similar providers:

Licensure/Certifications

License Type (DPH, DMH, etc.)		License Number:	
Medicare Certified?	☐ Y ☐ N	Certification Number:	
Medicaid Certified?	☐ Y ☐ N	Certification Number:	
Accredited/Certified?	☐ Y ☐ N	Accreditation/Certifying Agency:	

Signature Authority:	Date: