Contracting Application

Revised September 2025

Contracting Application Instructions & Checklist

Important: Please read all instructions and information before completing and signing this application.

To ensure timely processing of your request, please include the following documents with your submission:

- ☐ A completed and signed copy of this application
- ☐ HCAS Provider Enrollment Form (For enrollments of 10 practitioners on less)
- ☐ A completed CCA roster template of the practitioners, under your organization, rendering services to CCA members (For enrollments of 10 practitioners or more)

  Note: To stay consistent with NCQA Health Equity Accreditation requirements, CCA is capturing network demographic information to review the diversity of our network and assist members in selecting providers aligned with member preferences. Please utilize CCA's roster, accompanied by this application, to provide the information.
- ☐ A completed and signed W-9 Form.
- ☐ License Copy –State issued license or, if your provider type is not licensed by the state, a copy of your license to operate a business in your state.
- ☐ Drug Enforcement Agency (DEA) Certificate copy
- ☐ Accreditation Certificate(s)

  Centers for Medicare & Medicaid Services (CMS) Certification Letter
- ☐ Professional and General Liability Insurance Face Sheets
- ☐ Disclosure of Ownership Form

State Specific, as applicable:

- ☐ Massachusetts Controlled Substance Registration (MCSR)
- ☐ MassHealth Certification Letter
- ☐ Massachusetts DPH Site Survey

Section 1: General Information

Please select the option(s) that apply:

☐ **Sole Proprietor**
A practice that is owned by the practicing provider.

☐ **Provider Group**
A medical group, independent practice association, or any other similar organization.

☐ **Services Provider**
Atypical providers are providers who do not provide medical services (ex: non-emergency transportation, case mgmt, or environmental modifications).

☐ **Facility**
Facility type providers include but are not limited to Hospitals, Skilled Nursing, Assisted Living, etc.

Name: _____
(As shown on your tax return)

DBA (if any): _____

Federal Tax ID (TIN or SSN) #: _____
Please indicate: ☐ TIN ☐ SSN

National Provider Identifier (NPI): _____
Must be Type 2 NPI for groups/facilities. For additional NPI's associated with TIN, please complete Section 13 of this application.

Home Page URL: _____

Medicare #: _____ **Federal DEA:** _____ **CAQH ID:** _____

Medicaid #: _____ **Medicaid State:** ____ **State License #:** _____ **State of Licensure:** ____

NCQA recommends the collection of race, ethnicity, and language information in support of health equity programs and issues. If submitting an HCAS for one (1) practitioner, indicate this information below. For more than one (1) practitioner, please include these details on the CCA roster accompanied by this application.

Practitioner Race: _____ **Practitioner Ethnicity:** _____ **Practitioner Language:** _____

Section 2: Address Information

For additional addresses, please see Section 13

Please select the option(s) that apply:

Address Type: ☐ Primary ☐ Secondary ☐ Mailing/Correspondance

Street: _____ **Suite #:** _____

City: _____ **State:** ____ **Zip Code:** _____ **Phone:** _____ **Fax:** _____

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:	_____	_____	_____	_____	_____	_____	_____
Close:	_____	_____	_____	_____	_____	_____	_____

ADA Compliance: Does this service address comply with the American with Disabilities Act (ADA)? ☐ **Yes** ☐ **No**

Languages spoken by office staff (*list all*): _____

Accommodations available at this location:

☐ Accommodations for Persons with Cognitive Disabilities
☐ Accommodations for Persons with Hearing Impairment
☐ Accommodations for Persons with Visual Impairment
☐ Cultural Training
☐ Telehealth
☐ Interpreter Services Available
☐ Bilingual staff or onsite interpreters
☐ Remote video or telephone interpreters
☐ American Sign Language (ASL) interpreters
☐ Other: _____

Section 3: Billing/Remit Address and Claims Information

Street: _____			**Suite #:** _____	
City: _____	**State:** ____	**Zip Code:** _____	**Phone:** _____	**Fax:** _____
What form do you use to submit claims? ☐ UB-04 ☐ 1500 ☐ Both *(if both, identify services billed on each form)*				
Services billed on UB-04: _____		Services billed on 1500: _____		

Please note: When submitting multiple service addresses, if remit address is different for each NPI, please indicate in Section 13.

Section 4: Counties Served Check all that apply

Massachusetts:

☐ Barnstable
☐ Berkshire
☐ Bristol
☐ Dukes
☐ Essex
☐ Franklin
☐ Hampden
☐ Hampshire
☐ Middlesex
☐ Nantucket
☐ Norfolk
☐ Plymouth
☐ Suffolk
☐ Worcester

Rhode Island:

☐ Bristol
☐ Kent
☐ Newport
☐ Providence
☐ Washington

Section 5: Contact Information

	Name	Phone Number	Email
Primary Contact	_____	_____	_____
Billing	_____	_____	_____
Clinical	_____	_____	_____
Credentialing	_____	_____	_____
Medical Records	_____	_____	_____

Section 6: Provider Types *Check all that apply*

☐ Adult Day Health
☐ Adult Foster Care
☐ Ambulatory Surgical Center
☐ Assisted Living Facility
☐ Behavioral Health: Facility *(See services checklist)*
☐ Behavioral Health: Individual Clinician
☐ Behavioral Health: Outpatient Group
☐ Certified Home Health Agency
☐ Chiropractic
☐ Clinical Laboratory
☐ Comprehensive Outpatient Rehab Facility (CORF)
☐ Day Habilitation
☐ Day Services
☐ Diagnostic Radiology/Imaging Center
☐ Dialysis Outpatient
☐ Durable Medical Equipment
☐ Federally Qualified Health Center (FQHC)
☐ Group Adult Foster Care
☐ Hearing Aid
☐ Home Care Services
☐ Home Infusion Therapy
☐ Home Modifications
☐ Hospice
☐ Hospital – Psychiatric
☐ Hospital – Acute Care
☐ Hospital – Long Term Acute Care
☐ Hospital – Rehabilitation
☐ Independent Diagnostic Testing Facility (IDTF)
☐ Independent Living Center
☐ Mobile Imaging
☐ Mobile Laboratory
☐ Occupational Therapy
☐ Optical Shop/Eyeglass Center
☐ Optometry
☐ Physical Therapy
☐ Physician Group Practice
☐ Primary Care Site
☐ Registered Dietician
☐ Skilled Nursing Facility
☐ Sleep Disorder Center
☐ Speech Therapy
☐ Urgent Care
☐ Other: _____

Section 7: Certifications & Accreditations

If your organization is not accredited by a recognized accrediting agency, a site visit will need to be conducted by CMS or Medicaid. A copy of your CMS or MassHealth inspection results letter may be accepted in lieu of an accreditation.

Medicare Certified? ☐ Yes ☐ No

Medicaid Certified? ☐ Yes ☐ No

Accrediting Agency:
_____

Section 8: Minority Owned Business Self Disclosure

A minority or Women Business Enterprise (MBE/WBE) is a business where at least 51% is owned, operated, and controlled daily by one or more citizens who are an ethnic minority and/or female and/or a service-disabled veteran.

☐ Yes ☐ No

If you have selected "Yes" to any of these, please submit proof of documentation.

- ☐ Certified 8(a) Firms (8A)
- ☐ Disadvantaged Business Certification (DBE)
- ☐ Greater New England Minority Supplier Development Council (GNEMSDC)
- ☐ HubZone Businesses
- ☐ Lesbian, Gay, Bisexual, Transgender Businesses (NGLCC)
- ☐ Minority-Owned Business (MBE)
- ☐ People with Disabilities (USBLN/DSDP)
- ☐ Small Disadvantaged Businesses (SDB/SBA)
- ☐ Service-Disabled Veteran-Owned (SDVOB)
- ☐ Veteran Owned Business (VO)
- ☐ Women Owned Business (WBE)

Section 9: Compliance Questionnaire

CCA maintains the right to request documentation supporting compliance with these criteria. If requested, the organization must supply documentation within 30 days of notice.

If your organization is an Inpatient Behavioral Health Hospital:		
1. Does your hospital have a human rights protocol that is consistent with Department of Mental Health requirements and have human rights protocol training for staff?	☐ Yes	☐ No
2. Does your hospital have a human rights officer that is overseen by a human rights committee?	☐ Yes	☐ No
If your organization is a Home and Community Based Service Provider:		
1. Does your organization complete a criminal background check (CORI check) on all servicing employees?	☐ Yes	☐ No
2. Does your organization ensure all servicing employees meet the minimum qualification requirements?	☐ Yes	☐ No
3. Does your organization ensure all servicing employees have completed training regarding mandatory reporting of suspected elder abuse?	☐ Yes	☐ No
If your organization has Primary Care Providers (PCP's):		
1. Does your organization have the ability to communicate with patients in a linguistically appropriate and culturally sensitive manner?	☐ Yes	☐ No

Section 10: Attestation Questionnaire

1. Has your organization's clinical or business license to practice in any state ever been denied, limited, suspended, or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	☐ Yes	☐ No
2. Have your organization's privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily) or been called before or warned regarding these privileges by this state or any jurisdiction or federal agency at any time? Is any such action currently pending?	☐ Yes	☐ No
3. Have any formal or written complaints been filed against your organization?	☐ Yes	☐ No
4. Have any memberships in professional organizations and/or accreditations been denied, limited, suspended, or revoked, diminished, not renewed, relinquished (whether voluntary or involuntary) to your organization?	☐ Yes	☐ No
5. Have there been any suits or claims against you alleging malpractice, negligence, failure to diagnose, etc. which have been pending, opened, or closed during the past ten (10) years?	☐ Yes	☐ No

Section 11: Attestation Questionnaire Explanation

If you have answered "yes" to any of the questions on the Application, please supply the additional required information. Use a separate copy of this form for **each** question and indicate the number of the question to which you are responding.

Question #: _____

Facility Name: _____

Date of Action/Occurrence: _____

Date Claim/Complaint/Criminal Case was filed: _____

Status of Claim/Complaint/Criminal Care:
☐ Open ☐ Closed – Date of closure: _____

Date of Settlement: _____

Amount of Settlement: _____

Method of Resolution:
☐ Dismissed Judgment for Plaintiff(s)
☐ Settled with Prejudice Settled without Prejudice
☐ Judgment for Defendant(s) Mediation or Arbitration
☐ Letter of advice, consent agreement, letter of concern, warning
☐ Letter, PHS agreement, other (please include a copy)

Detailed Description:

Section 12: Release of Information, Attestation & Signature

The undersigned hereby attests that the information in or attached to this application is true and complete and fairly represents the information requested. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may constitute sufficient cause for rejection of this application resulting in denial of network participation.

I hereby authorize any organization or individuals who have information bearing on this organizational or facility provider's credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications to provider and/or release information (both written and oral) to Commonwealth Care Alliance. Such information includes but is not limited to information regarding any and all malpractice actions, pending or final disciplinary actions, and any information with respect to whether the organization or facility can perform the essential functions of the position for which it is applying.

Signature: _____

Name: _____

Title: _____ Date: _____

commonwealth care alliance

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Section 13: Additional Addresses

TIN must match TIN in Section 1

Please select the option(s) that apply:					Address Type: ☐ Additional ☐ Billing/Remit ☐ Mailing/Correspondance		
Street:					**Suite #:**	**NPI:**	**TIN:**
City:			**State:**		**Zip Code:**	**Phone:**	**Fax:**
Hours of Operation:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							

Languages spoken by office staff (*list all*):

_____

_____

Accommodations available at this location:

Accommodations for: ☐ Persons with Cognitive Disabilities
☐ Persons with Hearing Impairment ☐ Persons with Visual Impairment
☐ Cultural Training ☐ Telehealth
☐ Other accomodations: _____

☐ Interpreter Services Available such as:
☐ Bilingual staff or onsite interpreters
☐ Remote video or telephone interpreters
☐ American Sign Language (ASL) translators

ADA Compliance: Does this service address comply with the Americans with Disabilities Act (ADA)? ☐ **Yes** ☐ **No**

Please select the option(s) that apply:					Address Type: ☐ Additional ☐ Billing/Remit ☐ Mailing/Correspondance		
Street:					**Suite #:**	**NPI:**	**TIN:**
City:			**State:**		**Zip Code:**	**Phone:**	**Fax:**
Hours of Operation:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							

Languages spoken by office staff (*list all*):

_____

_____

Accommodations available at this location:

Accommodations for: ☐ Persons with Cognitive Disabilities
☐ Persons with Hearing Impairment ☐ Persons with Visual Impairment
☐ Cultural Training ☐ Telehealth
☐ Other accomodations: _____

☐ Interpreter Services Available such as:
☐ Bilingual staff or onsite interpreters
☐ Remote video or telephone interpreters
☐ American Sign Language (ASL) translators

ADA Compliance: Does this service address comply with the Americans with Disabilities Act (ADA)? ☐ **Yes** ☐ **No**

For additional addresses, please provide a copy of this section of the application.