Letters of Interest Contract Request Form

Before you begin, please indicate with an X if you are submitting Request with Interest in Participating with our Plan, WellSense Health Plan, MA or NH

NH- WellSense Health Plan_____ **MA** – WellSense Health Plan (formerly known as BMCHP)_____

Provider Name (DBA/to be displayed in directory): _____

Provider Legal Name (directly from W9) if different from above: _____

Tax ID (W-9 must be submitted with request): _____

Practice Address:

_____

_____

_____

Phone Number: _____

Fax Number: _____

Billing Address:

_____

_____

_____

Phone Number: _____

Fax Number: _____

Note: For more locations, please provide on a separate sheet of paper.

Office Manager **Name** and E-Mail Address (Required): _____

Office Manager Contact Address: _____

_____

Credentialing Contact Name and E-Mail Address:_____

Credentialing Contact Address: _____

_____

Legal Notices: Future Plan notices, contract related documents and legal communications will be in writing and submitted to the following Provider Chief Financial Officer (CFO) or other Provider Contracting Contact and mailing address:

CFO or Contracting Contact Name and Email (Required):_____

CFO or Contracting Contact Legal Mailing Address (Required): _____

_____

_____

Provider Information (if Group request, include all Providers in the Group): provide extra sheet if necessary

Provider/Provider Group Name:	**Specialty:**		**Hospital Affiliation(s)*:**	**Provider NPI:**
_____	_____	PCP Y/N	_____	_____
_____	_____	PCP Y/N	_____	_____
_____	_____	PCP Y/N	_____	_____
_____	_____	PCP Y/N	_____	_____
_____	_____	PCP Y/N	_____	_____

Please let us know your Panel status if Providers are PCP's: Open / Closed

*Physicians must have hospital admitting privileges at a WellSense Health Plan contracted hospital or must provide explanation of arrangements in place for members to be admitted to a Plan participating hospital

Is this group part of a Massachusetts ACO? If Yes, which ACO? _____

Does the provider offer any special services? **YES** ☐ **NO** ☐

If Yes, please list: _____

What language(s) does the provider(s) speak? _____

What languages are spoken by the office staff? _____

Population Served: (optional): _____

Why is the provider interested in contracting with WellSense Health Plan (MA or NH)? _____

_____

Does the interested provider offer any special services that should be taken into consideration when reviewing this request for an Agreement for participation? If yes, please share:

_____

_____

Has the provider received requests to care for any of our members? **YES** ☐ **NO** ☐

Is the entity/practitioners NH Medicaid approved? **YES** ☐ **NO** ☐ _____

Is the entity/practitioners MassHealth approved? **YES** ☐ **NO** ☐ _____

Type of Agreement requested:

Individual Contract:	**YES** ☐	**NO** ☐	Group Contract:	**YES** ☐	**NO** ☐
			Group < 25 practitioners:	**YES** ☐	**NO** ☐
Facility Contract:	**YES** ☐	**NO** ☐	Ancillary Contract:	**YES** ☐	**NO** ☐

Facility Provider Type: _____ Ancillary Provider Type: _____

For MA providers interested in joining WellSense Health Plan (MA) ONLY:

Those interested in joining WellSense Health Plan (MA) are required to be MassHealth contracted. For those who are not MassHealth contracted, you must apply with MH for a MassHealth Nonbilling Managed Care Entity (MCE) Network Only Provider Contract. Visit: https://www.mass.gov/forms/submit-the-masshealth-nonbilling-managed-care-entity-network-only-provider-contract

You must be contracted with MassHealth in the same manner you are requesting to contract with Boston Medical Center HealthNet Plan. For example, if you are a requesting a Group Contract under a Group Tax Identification Number, you must be contracted with MH as a Group Entity as well. The same applies to requests for Individual Entity Contracts, and Facilities, etc. If the contract differs, you must apply for the Nonbilling Managed Care Entity Network Only Provider Contract as noted above.

If No, have you applied with MH for the required Nonbilling Managed Care Entity Network Only Provider Contract as noted above? **YES** ☐ **NO** ☐

Please return completed form and W-9 to support the Contract Type requested above via e-mail to:
Massachusetts/WellSense: Provider.Info@bmchp-wellsense.org; OR
New Hampshire/WellSense: NHProviderInfo@bmchp-wellsense.org

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Below to be completed by Provider Engagement or Provider Processing Center

Date Request Received:	Processed by:	Added into Database:	Completed on: