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

Please Note: This is not an Agreement or a Contract. This is a Request for consideration to become a provider in the WellSense Provider Network that will be reviewed for consideration. This does not warrant payment or an effective date of being in the WellSense Provider Network.

If request is approved, contracts will be sent to you and credentialing is required. Until you are credentialed, contracted, and notified that you are in the WellSense Provider Network as a participating provider, you are considered Out of Network. All Out of Network providers required authorization to provide care to WellSense members. Services provided without authorization will deny. Your effective date for participation is not based upon submission of this request, it will be based solely upon your credentialing and contracting, if, when, approved.

Please complete Form in TYPE or in clear PRINT to avoid return of form and delays.

NH- WellSense Health Plan_____ **MA** – WellSense Health Plan (fka 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): _____

Primary Practice Address:

_____

_____

_____

Phone Number: _____
Fax Number: _____

Billing Address:

_____

_____

_____

Phone Number: _____
Fax Number: _____

Note: For additional locations, please provide a separate sheet of paper

Office Manager **Name** and e-mail Address (Required): _____

Office Manager Contact Address: _____

_____

Office Manager Phone Number_____

Credentialing Contact Name and e-mail Address: _____

Credentialing Contact Address: _____

_____

Credentialing Contact Phone Number: _____

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 e-mail (Required):_____

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

_____

_____

CFO or Contracting Contact Phone Number_____

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

*Please provide your specialty- this is very important.

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): _____

Ages Served: _____

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** ☐ Please Provide NH Medicaid ID(s)

_____

_____

_____

_____

Is/are the entity/practitioners MassHealth approved? **YES** ☐ **NO** ☐ Please Provide PID/SL(s)

_____

_____

_____

_____

_____

Type of Agreement requested:

Please ensure your W9 and Tax ID support the below:

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:

Providers who are not MassHealth contracted, 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. This is the case for addresses, NPI's and TIN's under your agreement that are not recognized by MH.

Under this Agreement, you must be contracted with MassHealth (MH) in the same manner you are requesting to contract with WellSense Health 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 you are not contracted with MH as FFS provider, 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

Below to be completed by Provider Engagement or Provider Processing Center

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