



Serving the MassHealth Program\*

**MassHealth Dental**  
**12121 North Corporate Parkway**  
**Mequon, Wisconsin 53092, Attn: Provider Credentialing**  
(800)207- 5019  
[www.masshealth-dental.net](http://www.masshealth-dental.net)

Welcome to the MassHealth dental program. If you have any questions about any aspect of the application process, please call Doral at **800-207- 5019** (Monday thru Friday from 8:00 A.M. to 6:00 P.M. Eastern Time) **Do not fill out this application IF you are already a MassHealth provider joining an existing dental practice that is also a MassHealth provider.** Send a letter to Doral, at the address above explaining that you are a MassHealth provider wishing to join an existing practice. Please be sure to include your provider number, and the practice's name and provider number.

#### **Instructions:**

Send your complete application with original signatures to Doral at the address above. Incomplete applications will delay the processing of your application.

**If you are a dental specialist** such as an endodontist, oral surgeon, orthodontist, pedodontist, or periodontist you must include with your application a copy of your Certification in Advance Graduate Studies.

**Get your money faster.** To receive payments by **direct deposit** (optional) fill out the EFT form included with the application.

**Tax reporting** for all payments will be made based upon the information required on page 2 of this application. The Legal Name, Business Type, Legal and remittance address and tax identification number (SSN, TIN or EIN) must match what you have already filed with the IRS and Massachusetts Dept. of Revenue for you or your firm. (Please see your most recent tax return for this information.)

For further instructions, please refer to the particular instructions on the next page that match your provider status.

**Please note:** You must receive approval from Doral in the form of a welcome letter before you may begin to treat MassHealth members and seek payment for services provided.

**IF YOU ARE A TREATING DENTIST (APPLYING ON YOUR OWN) WHO HAS NOT FORMED A LEGAL ENTITY (CORPORATION, PARTNERSHIP OR TRUST) OR YOU ARE A TREATING DENTIST JOINING A LEGAL ENTITY BUT NOT THE AUTHORIZED REPRESENTATIVE:**

Complete Column A (but disregard column B) of page 2.


Complete pages 3, 4.


Complete Column A (but disregard column B) of page 5.

Check off box at top of page 6 but disregard the rest of page 6. Disregard pages 7 and 8.

Complete the Provider Agreement Column A (but disregard column B) on page 9.

*Specialists Only:* Attach a copy of your Certificate in Advance Studies

 Sign as the TREATING DENTIST on pages 2 and 12 (Column A) Original signature required.

 Sign the Electronic Funds Transfer Form (EFT) – OPTIONAL. Original signature required.

**IF YOU ARE A TREATING DENTIST WHO HAS FORMED A LEGAL ENTITY:**

Complete Column A of page 2 as the treating dentist.

Complete Column B of page 2 as the representative of the corporation, partnership or trust.

Complete page 3 as the treating dentist.


Complete pages 4, 6, 7, and 8 as the representative of the corporation, partnership or trust.


Complete Columns A and B of page 5 both as a treating dentist and representative.

Complete Columns A and B (Provider Agreement) on page 9 both as a treating dentist and representative.

*Specialists Only:* Attach a copy of your Certificate in Advance Studies.

 Sign as the TREATING DENTIST on pages 2 and 12 (Column A) **AND**

 Sign as the Authorized Representative of the corporation, partnership or trust on pages 2 and 12 (Column B). Original signature required.

 Sign the Electronic Funds Transfer Form (EFT) – OPTIONAL. Original signature required.

**IF YOU ARE AN AUTHORIZED REPRESENTATIVE OF A DENTAL PRACTICE CORPORATION, PARTNERSHIP, OR TRUST AND NOT A TREATING DENTIST:**


Complete Column B (but disregard column A) of page 2.


Disregard page 3.

Complete pages 4- 8.

Complete Column B (but disregard column A) of page 5.

Complete the MassHealth Provider Agreement in Column B (but disregard column A) on page 9.

 Sign as the Authorized Representative of the corporation, partnership or trust on pages 2 and 12 (Column B). Original signature required.

 Sign the Electronic Funds Transfer Form (EFT) – OPTIONAL. Original signature required.

# MASSHEALTH DENTAL PROVIDER APPLICATION


**Note on Credentialing.** All providers are credentialed following the guidelines of the National Committee for Quality Assurance (NCQA) to ensure MassHealth members are receiving the best quality care possible.

**All applications are subject to review and approval by Doral.** All information contained in a credentialing file will be held in strict confidence, and available for review by only duly authorized employees of MassHealth and/or third party review organizations (i.e. NCQA, etc.). An applicant has the right to obtain a copy of the credentialing file, by submitting a written, signed request to the Credentialing Department at Doral at the address on the cover page. Any corrections, additions, or clarifications to these files must be submitted in writing to the Credentialing Department. The applicant has the right, upon request, to be informed of the status of their credentialing or recredentialing application via phone, fax, or mail.

In the event that a dentist's application for participation is rejected or limited for reasons pertaining to the applicant's professional conduct or competence, Doral is required to submit a report to MassHealth. MassHealth will submit a report to the National Practitioner Data Bank and the state licensing board as required by law.

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**Note: To ensure accurate reporting of your federal identification number** you may want to obtain and include in your application a copy of ANY preprinted Internal Revenue Service ("IRS") document, coupon, or voucher showing your TIN/EIN (04- xxxxxxx) or (02- xxxxxxx ) number. Your tax preparer would have this record if you do not.

LEGAL NAME, ADDRESS & TAX ID MUST BE THE SAME AS WILL APPEAR ON IRS TAX RETURNS	COLUMN A TREATING DENTIST OR TREATING DENTIST AS SOLE PROPRIETOR	COLUMN B LEGAL ENTITY (Corporation, Partnership or Trust) only
	Do you intend to bill under your own provider number at this time? No <input type="checkbox"/> YES <input type="checkbox"/>	
<b>Legal Name</b> Include Jr., III or other Include Professional Title DMD, DDS, etc.	Treating Dentist's Name (Last, First and MI) (Print)	Business Name (Print)
Date of Birth	(MM/DD/YYYY)	
Business Name if different from above	D/B/A if applicable	D/B/A if applicable
Check the Appropriate Box:	1 Treating Dentist <input type="checkbox"/> 2 Treating Dentist/Sole Proprietor <input type="checkbox"/>	3 Professional Corp. (One practitioner only) <input type="checkbox"/> 4 Professional Corp. <input type="checkbox"/> 9 Trust <input type="checkbox"/> (Two or more practitioners only) 6 Business Corp. <input type="checkbox"/> 7 Nonprofit Corp. <input type="checkbox"/> 8 Partnership (Includes unincorporated group practice) <input type="checkbox"/>
<b>Legal Address</b> Street	Your <b>HOME</b> address (cannot be P.O. Box)	Legal address of business entity
City/ State/Zip/County		
Telephone Number		
Contact Name		
Fax Number		
Email address		
Federal Tax Identification Number (TIN) ✓ Check which you are entering Type 1 SSN <input type="checkbox"/> Type 2 EIN <input type="checkbox"/>	Enter your Employer Identification Number ("EIN") if you are a sole proprietor and have an EIN number <u>otherwise</u> enter your social security number. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Employer Identification Number (EIN) 02-xxxxxxx or 04-xxxxxxx TIN/EIN: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Primary Service Site Office Name</b>		
Street Address		
City/State/ Zip Code		
Telephone Number		
Contact Name		
Fax Number		
Email address		
<b>Payment Type</b>	Check One: Bank Check <input type="checkbox"/> EFT <input type="checkbox"/> If EFT remember to complete the EFT form	Check One: Bank Check <input type="checkbox"/> EFT <input type="checkbox"/> If EFT remember to complete the EFT form
<b>Check Remittance Information</b>	Where do you want to receive your <b>Check and/ or Remittance</b> advices? Provide address below.	Where do you want to receive your <b>Check and/ or Remittance</b> advices? Provide address below.
Address		
City/ State/Zip Code		
Telephone Number		
Contact Name		
Fax Number		
	I certify under the pains and penalties of perjury that the tax identification number I have provided is correct.	As authorized representative I certify under the pains and penalties of perjury that the tax identification number provided is correct.
<i>Signature</i> 		
<b>Signed by:</b> <b>Print Name</b>		

If you are applying to become a **MassHealth Provider**, and you are **joining an existing practice** enter directly below, the name and MassHealth Number of the practice you are joining.

Name	MassHealth Provider Number	NPI Number

**TREATING DENTIST LICENSE AND IDENTIFICATION NUMBERS**

<p><b>Name:</b> _____</p> <p><b>Social Security Number</b></p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p>SSN Type 1</p> <p><b>NPI Individual</b> (National Provider Identifier)</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p><b>MassHealth Number</b> (If you have one already)</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table> <p>Check the appropriate code that identifies your Provider Type</p> <p><input type="checkbox"/> 10 = Dentist</p> <p><input type="checkbox"/> 11 = Dental Clinic</p> <p><input type="checkbox"/> 12 = Dental School Clinic, Undergrad</p> <p><input type="checkbox"/> 13 = Dental School Clinic, Grad</p> <p>Legal Entity 1</p> <p>Ownership 9</p>																																																		<p><b>Professional License Number</b> _____</p> <p>State _____</p> <p>Effective Date _____</p> <p>Expiration Date _____</p> <p>Check the appropriate code that identifies the licensing authority for your provider type</p> <p><input type="checkbox"/> 02 = Massachusetts Board of Registration in Dentistry</p> <p><input type="checkbox"/> 21 = Out of State License (Out of State Providers)</p> <p><input type="checkbox"/> 26 = Massachusetts Department of Public Health Clinic Licensure (Dental School Clinics and Dental Clinics)</p> <p><b>DEA Number</b> _____</p> <p>State _____</p> <p>Effective Date _____</p> <p>Expiration Date _____</p> <p><b>Anesthesia License Number</b> _____</p> <p>State _____</p> <p>Effective Date _____</p> <p>Expiration Date _____</p> <p>Check the appropriate code that identifies the type of anesthesia administered in your office</p> <p><input type="checkbox"/> 0 = None</p> <p><input type="checkbox"/> 1 = General Anesthesia Intravenous Sedation</p> <p><input type="checkbox"/> 2 = Analgesia Inhalation Nitrous Oxide (N<sub>2</sub>O/O<sub>2</sub>)</p> <p><input type="checkbox"/> 3 = Both</p>

Check the Specialty Board(s) by which you are certified. If you are a dental specialist you must include with your application a copy of your Certification in Advance Graduate Studies.	Check	Certification Date
600 Orthodontics	<input type="checkbox"/>	
620 General Dentistry	<input type="checkbox"/>	
621 Oral Surgery	<input type="checkbox"/>	
622 Endodontics	<input type="checkbox"/>	
623 Pedodontics	<input type="checkbox"/>	
624 Periodontics	<input type="checkbox"/>	
625 Prosthodontics	<input type="checkbox"/>	
626 Geriatric Dentistry	<input type="checkbox"/>	
<b>Dental Clinics &amp; Dental School Clinics --- Check appropriate block below. Attach a copy of your Clinic License from DPH.</b>		<b>Certification Date</b>
601 Dental School Clinic – Undergraduate	<input type="checkbox"/>	
602 Dental School Clinic – Graduate	<input type="checkbox"/>	
603 Dental School Clinic - Graduate Orthodontics	<input type="checkbox"/>	
604 Dental Clinic	<input type="checkbox"/>	

## Practice Information and Office Details

Practice Type (Check one): Adults Only  Children Only  Adults & Children

If you treat children, minimum age \_\_\_\_\_

Does your practice treat special needs (physically and/or mentally impaired) members?

Yes  No

Office Hours Primary Location	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Do you have coverage after normal business hours? \_\_\_\_\_ If so, please list contact information:

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Languages spoken at office (Check all that apply):

English   
 Spanish   
 Arabic   
 Chinese

French   
 German   
 Hmong   
 Hindi

Laotian   
 Philippine   
 Vietnamese   
 Other (Please list)

Is your office capable of handling hearing impaired Individuals? Yes  No

Is your office capable of handling visually impaired Individuals? Yes  No

Is your office handicapped accessible? Yes  No

Number of treatment chairs

Does your office have a personal computer? Yes  No

Does your office have Internet Access? Yes  No

### Treating Dentist ONLY

Hospital Name	Address	City	State

Attach additional pages if necessary.

**ATTESTATION AND RELEASE OF INFORMATION**

**COLUMN A : TREATING DENTIST ONLY**

**COLUMN B: CORPORATION, PARTNERSHIP, TRUST**

Yes	No	#		Yes	No	#	
		<b>1</b>	Has your Dental License been limited, suspended, denied, revoked, restricted, subject to probationary conditions, or have proceedings been instituted against you?			<b>13</b>	Have any disciplinary actions been threatened or initiated, or are any disciplinary actions pending against the entity or any member of the entity by a state licensure board?
		<b>2</b>	Have you voluntarily relinquished, reduced, restricted, or otherwise limited your dental license in any jurisdiction?			<b>14</b>	Has license of any member of the entity to practice in any state ever been denied, limited, suspended, revoked, diminished, not renewed, or relinquished (whether voluntarily or involuntarily)?
		<b>3</b>	Have you been reprimanded or disciplined by any State or Commonwealth Department of Regulation and Licensure of the Dental Examining Board?			<b>15</b>	Are proceedings currently pending which may result in the license of a member of the entity to practice in any state being denied, limited, suspended, revoked, diminished, not renewed, or relinquished (whether voluntarily or involuntarily)?
		<b>4</b>	Has your participation for receiving payment under MassHealth been suspended or limited <u>other</u> than by your voluntary termination?			<b>16</b>	Has the medical staff appointment or have privileges ever been limited, suspended, revoked, diminished, refused/denied, terminated, restricted, not renewed, or relinquished (whether voluntarily or involuntarily), at any hospital or health-care facility?
		<b>5</b>	Have you been convicted of any criminal offenses, pending or otherwise, other than a minor traffic violation?			<b>17</b>	Are proceedings currently pending which may result in medical staff appointment or privileges being limited suspended, revoked, diminished, refused/denied, terminated, restricted, not renewed, or relinquished (whether voluntarily or involuntarily), at any hospital or health-care facility?
		<b>6</b>	Have there been any suits or claims against you alleging malpractice, negligence, failure to diagnose, etc., that are pending or have opened or closed including settled during the past 10 years?			<b>18</b>	Has the entity or any member of the entity ever been suspended, sanctioned, or restricted from participating in any private, federal, or state health program (for example, Medicare, or Blue Cross/Blue Shield)?
		<b>7</b>	Has your liability insurer placed any conditions or restrictions on your coverage or ability to attain coverage?			<b>19</b>	Does the entity or any member of the entity have any financial interest (directly or through family or business partners) in any laboratory, pharmacy, medical equipment or supply house or other business to which patients under the entity's care might be referred or recommended?
		<b>8</b>	Are you, or have you been, under the treatment for the use of narcotics, barbiturates, alcohol, or other drugs?			<b>20</b>	Have there been any suits or claims against the entity or any member of the entity alleging malpractice, negligence, failure to diagnose, etc., that are pending or have opened or closed during the past 10 years?
		<b>9</b>	Do you presently have any physical or mental condition that would adversely affect your ability to provide high quality professional services? If there are there any accommodations that need to be considered, please list on a separate page.			<b>21</b>	Has any member of the entity ever been convicted in a criminal action? Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace, or any conviction of a misdemeanor more than five years before this application if there has been no criminal conviction of any offense within five years of this application.
		<b>10</b>	Has your Drug Enforcement Agency (DEA) registration been denied, revoked, suspended, not renewed or have you voluntarily surrendered, reduced, or limited your DEA registration? (If you do not have a DEA or your DEA does not list all schedules 2, 2N, 3, 3N, 4, and 5; please provide an explanation.)			<b>22</b>	Has the entity or any member of the entity ever been the subject of an inquiry or disciplinary action by any governmental or other regulatory agency or is any such action pending? If yes, include all documentation relating to all inquiries, whether action was taken, dismissed, or pending. Attach a copy of any complaints, responses to complaints, and Board of Registration letters.
		<b>11</b>	Has your participation with a managed care organization, other health care organization or hospital privileges ever been suspended, limited, or terminated?				
		<b>12</b>	Are you engaged in the illegal use of drugs?				

**If you answer YES to any of the above, provide a detailed explanation on a separate page. Question # \_\_\_\_ Explain:**

**If you answer YES to any of the above, provide a detailed explanation on a separate page. Question # \_\_\_\_ Explain:**

**DENTAL ENTITY ONLY** (CORPORATION, PARTNERSHIP OR TRUST)

Check here if you are a treating dentist who has not formed a legal entity or a treating dentist who is not the legal representative of a dental practice. If you checked this box ignore the rest of this page.

Practice Name \_\_\_\_\_

**NPI Group** (National Provider Identifier)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**NPI Sub-Part** (If you have more than one location and wish to bill separately, you must obtain a separate subpart NPI for each location. Otherwise you will receive one remittance statement and check for both locations.)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please type or print the name of each treating dentist, **who will treat MassHealth members**, who is part of your practice. Include First Name, Middle Initial, and Last Name.

Name		MassHealth Provider Number	NPI
Taxonomy	Specialty	Specialty	

Name		MassHealth Provider Number	NPI
Taxonomy	Specialty	Specialty	

Name		MassHealth Provider Number	NPI
Taxonomy	Specialty	Specialty	

Name		MassHealth Provider Number	NPI
Taxonomy	Specialty	Specialty	

If you have additional treating dentists who will treat MassHealth members print multiple copies of this page, complete the requested information, and include extra page(s) with your application.

DENTAL ENTITY only (corporation, partnership or trust)

**OFFICERS, DIRECTORS, PARTNERS, AND TRUSTEES**

If you are, or represent a Professional Corporation (of two or more practitioners), Government Agency, Business Corporation, Nonprofit Corporation, Partnership (Includes unincorporated group practitioners) or Trust, complete the information below for each officer, director, partner and trustee of the legal entity.

Last Name

First Name

M.I.

Number and Street

City/ State /Zip Code

Has the officer been convicted of a criminal offence related to the officer's involvement in any program established under Medicaid, Medicare, or the Social Security Act? **Check Yes  or No**

Position Title

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider?

**Check Yes  or No**  Check family relation: Spouse  Sibling  Parent  Child  Other  \_\_\_\_\_

Does the officer have an ownership or control interest in another MassHealth provider?

**Check Yes  or No**

If you have additional officers, directors, partners or trustees print multiple copies of this page, complete the requested information and include extra page(s) with your application.

**OWNERSHIP AND CONTROL INTEREST**

If there are individuals or entities having direct or indirect ownership or beneficial ownership of **five percent** or more in the legal entity complete the following information.

Check One: Individual  Entity

Last Name

First Name

M.I.

Number and Street

City/ State/ Zip Code

Has the interested party been convicted of a criminal offence related to the party's involvement in any program established under Medicaid, Medicare, or the Social Security Act? **Check Yes  or No**  If yes, attach description.

Percent Interest Held %

Type of Interest Held Check: Capital  Stock  Profit  Secured Credit

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider?

**Check Yes  No**  Check family relation: Spouse  Sibling  Parent  Child  Other  \_\_\_\_\_

Does the officer have an ownership or control interest in another MassHealth provider?

**Check Yes  No**

If there are additional individuals or entities having direct or indirect ownership or beneficial ownership of **five percent** or more in the legal entity print multiple copies of this page, complete required information and include the extra page(s) with your application.

### SUBCONTRACTOR

**Subcontractor** - an individual, agency, or entity to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or - an individual, agency, or entity with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the MassHealth Provider agreement.

Do you use any subcontractor as defined above? **Check Yes**  **No**  If yes complete the information below.

Check One: Individual  Entity

Name of Subcontractor

First Name

M.I.

Number and Street

City/ State /Zip Code

Has the subcontractor been convicted of a criminal offence related to the subcontractor's involvement in any program established under Medicaid, Medicare, or the Social Security Act? **Check Yes**  **or No**  If yes, attach description.

Percent Interest the Provider has in the Subcontractor \_\_\_\_\_ %

Type of Interest Held Check: Capital  Stock  Profit  Secured Credit

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider? **Check Yes**  **No**  Check family relation: Spouse  Sibling  Parent  Child  Other  \_\_\_\_\_

Does the subcontractor have an ownership or control interest in another MassHealth provider?

**Check Yes**  **No**

If you have more than one subcontractor print multiple copies of this page and complete one page for each subcontractor and include extra page(s) in your application.

### OTHER DISCLOSING ENTITY

**Other Disclosing Entity-** Any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation of any of the programs established under Medicare or the federal Social Security Act.

Are there individuals or entities listed on pages 7 and 8 of this application having an ownership or control interest of **five percent** or more in another Medicaid provider? **Check Yes**  **or No**  If yes complete the information below.

Check One: Individual  Entity

Name of Individual with Ownership or Control Interest

Name of other Medicaid Provider

Provider Number of other Medicaid Provider

Mailing Address of other Medicaid Provider

City/ State /Zip Code

If there are additional individuals or entities having ownership or control interest of **five percent** or more in another Medicaid Provider print multiple copies of this page, complete required information and include the extra page(s) with your application.

## MassHealth Provider Agreement

Provider Agreement between the Commonwealth of Massachusetts, acting by and through its Executive Office of Health and Human Services, Office of Medicaid (MassHealth), and

**COLUMN A**

**COLUMN B**

**Legal Name of Treating Dentist (Applicant)** (print) (hereinafter the Provider”), with a principal place of business located at:  
**ADDRESS:**

**Legal Name of Corporation, Partnership or Trust** (print) (hereinafter the “Provider”), with a principal place of business located at:  
**ADDRESS:**

**In consideration of the mutual promises contained herein, the parties agree as follows:**

**I. The Provider agrees:**

1. To comply with all state and federal statutes, rules, and regulations applicable to the Provider’s participation in MassHealth.
2. To provide services to eligible members without regard to religion, race, color, or national origin in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq. and its implementing regulations at 45 CFR Part 80), and without regard to handicap in compliance with Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. §794 and its implementing regulations at 45 CFR Part 84).
3. To keep such records as are necessary to disclose fully the extent of the services to members and to preserve these records for a minimum period of four years.
4. To furnish MassHealth and any other state and federal officials and agencies or their designees, upon request, with such information, including copies of medical records, regarding any services for which payment was claimed from MassHealth, to the extent permitted or authorized by law.

**II. MassHealth agrees:**

To pay the Provider at the rates set by the Massachusetts Division of Health Care Finance and Policy or contained in the applicable Division fee schedules for all payable services and goods actually and properly delivered to eligible members and properly billed to MassHealth both in accordance with the terms of this Provider Agreement and in accordance with all applicable federal and state laws, regulations, rules, and fee schedules.

**III. Trading Partnership**

For the purposes of this section of the Provider Agreement, the Provider is referred to as the “The Trading Partner.” Both parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Each party agrees to take all steps reasonably necessary to ensure that all electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder. Without limiting the generality of the preceding sentence, the parties agree as follows:

1. Each party will take reasonable care to ensure that the information submitted in each electronic transaction is timely, complete, accurate, and secure, and will take reasonable precautions to prevent unauthorized access to (a) its own and the other party's transmission and processing systems, (b) the transmissions themselves, and (c) the control structure applied to transmissions between them.
2. Each party is responsible for all costs, charges, or fees it may incur by transmitting electronic transactions to, or receiving electronic transactions from, the other party.
3. The Trading Partner will conform each electronic transaction submitted to MassHealth to the Specifications Addendum applicable to the transaction, and to the applicable Companion Guide. MassHealth may modify the Specifications Addendum and the Companion Guide at any time without amendment to this Trading Partner Agreement, but the Trading Partner shall not be required to implement such modifications sooner than 60 days after publication of the modified Specifications Addendum or Companion Guide, unless a shorter compliance period is necessary to conform to applicable federal law or regulation. Only the last issued Specifications Addendum of each type will be effective as of the date specified in the Specifications Addendum. MassHealth may reject any transaction that does not conform to the applicable Specifications Addendum and the Companion Guide.
4. Before initiating any transmission in HIPAA standard transaction format, and thereafter throughout the term of this Agreement, the Trading Partner will cooperate with MassHealth and MassHealth's Business Associates (i.e., vendors who perform certain functions on Mass Health's behalf) in such testing of the transmission and processing systems used in connection with MassHealth as MassHealth deems appropriate to ensure the accuracy, timeliness, completeness, and security of each data transmission.
5. Each party is solely responsible for the preservation, privacy, and security of data in its possession, including data in transmissions received from the other party and other persons. If either party receives from the other data not intended for it, the receiving party will immediately notify the sender to arrange for its return, re-transmission, or destruction, as the other party directs.
6. Termination or expiration of this Agreement or any other contract between the parties does not relieve either party of its obligations under this Agreement and under federal and state laws and regulations pertaining to the privacy and security of Individually Identifiable Health Information nor its obligations regarding the confidentiality of proprietary information.
7. The Trading Partner may authorize one or more intermediaries to electronically send or receive MassHealth data on its behalf. Every such intermediary must first be bound by written agreement with the Trading Partner to comply with applicable law and regulations, with the current applicable Specifications Addenda and Companion Guides, and with the terms of this Agreement. The Trading Partner agrees and represents that it will disclose its provider number, user ID number, password, and any other means that enable MassHealth data to be transmitted to or received from MassHealth, only to intermediaries with whom it has such agreements, or to members of its workforce, whom the Trading Partner has authorized to receive and transmit data on its behalf. The Trading Partner will be bound by and responsible for the acts and omissions of all such persons in the exchange of electronic data with MassHealth. The Trading Partner shall notify MassHealth of any event, such as the termination of its relationship with a previously authorized employee or intermediary that may require action to foreclose submission and receipt of transactions by persons

no longer authorized by the Trading Partner to act on its behalf. Use of an intermediary shall not relieve the Trading Partner of any risks or obligations assumed by it under this or any other agreement with MassHealth, or under applicable law and regulations. The Trading Partner will bear all costs resulting from its use of intermediaries.



**IV. The Provider and MassHealth mutually agree:**

1. That any Special Conditions that indicate they are to be incorporated into this Provider Agreement and that are signed by both parties to this Agreement will be deemed to be part of this Agreement and that in the event of any inconsistency between the Special Conditions and this Agreement, the former shall control.


2. That this Agreement shall take effect upon notification of acceptance by MassHealth and shall continue in effect until terminated by either party upon written notice to the other party; and that MassHealth may not terminate this Agreement without affording to the Provider any applicable right to contest such termination available under federal and state law and regulation that has been properly requested by the Provider.

**CERTIFICATION STATEMENTS AND SIGNATURE**

I hereby acknowledge that the information provided in this provider application is material to whether I can become a provider or, if I file on behalf of a dental entity, whether the entity will be permitted to become a provider. I hereby represent and warrant under the pains and penalties of perjury that all information provided herein is true to the best of my knowledge, and I agree to notify MassHealth in the event an error is discovered or when new events occur which alter the validity of any response herein. I hereby authorize MassHealth to consult with individuals or institutions with which I have been associated and with others, including but not limited to past and present malpractice carriers, educational institutions, and state licensing boards, who may have information bearing on my professional competence, character and ethical qualifications and authorize the release of any such written or oral verification as needed by MassHealth. I hereby release from liability for any such entity, institution or organization that provides information as part of the application process.

COLUMN A	COLUMN B
<p><b>As a treating dentist I certify under the pains and penalties of perjury that:</b></p> <ul style="list-style-type: none"> <li>➤ I have carefully reviewed this Provider Application and attached documents,</li> <li>➤ The tax identification number provided in Column A page 2 of the application is my correct taxpayer identification number. I am a U.S. person (including U.S. resident alien),</li> <li>➤ All information in the application and attachments is complete, correct and true to the best of my knowledge, and</li> </ul> <p> <b>Signed by:</b></p> <p>_____</p> <p>Legal name of Treating Dentist Applicant Signed under the pains and penalties of perjury</p> <p><b>Date:</b> _____</p> <p><b>Print Name:</b> _____</p> <p><b>Title:</b> _____</p>	<p><b>As authorized representative I certify under the pains and penalties of perjury that:</b></p> <ul style="list-style-type: none"> <li>➤ I have carefully reviewed this Provider Application and attached documents,</li> <li>➤ The tax identification number provided in Column B page 2 of the application is my correct taxpayer identification number. I am a U.S. person (including an U.S. resident alien),</li> <li>➤ All parties of material interest have been identified and include no persons or entities with a potential for profit from self-referral,</li> <li>➤ All services are provided by and under the “on Premise” supervision of a licensed dentist,</li> <li>➤ All information in the application and attachments is complete, correct and true to the best of my knowledge, and</li> </ul> <p> <b>Signed by:</b></p> <p>_____</p> <p>Authorized Representative of Corporation, Partnership or Trust Signed under the pains and penalties of perjury.</p> <p><b>Date:</b> _____</p> <p><b>Print Name:</b> _____</p> <p><b>Title:</b> _____</p>

If the applicant is a legal entity other than a person, the person signing this Provider Application on behalf of the applicant warrants that he/she has actual authority to do so.

 <b>Executive Office of Health and Human Services (MASSHEALTH)</b>	
By: _____ (Signature)	Name: _____ (Print)
Title: _____	Date: _____



Commonwealth of Massachusetts  
 Executive Office of Health and Human Services  
 Office of Medicaid  
 www.mass.gov/masshealth

**AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT)  
 OF MASSHEALTH PAYMENTS**

The undersigned hereby authorizes the Executive Office of Health and Human Services, through the State Treasurer, to deposit funds due into the bank account named below. This authorization will remain in effect until canceled or amended in writing.

Visit the MassHealth Web site at [www.mass.gov/masshealth](http://www.mass.gov/masshealth) for more information.

Please check one:  Initial authorization  Modification to existing authorization

MassHealth Provider No.: \_\_\_\_\_ Tax Identification No.: \_\_\_\_\_  
*(Leave blank if you are a new provider.)*

Provider Name: \_\_\_\_\_  
*(Please indicate "doing business as" name and address.)*

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ - \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Transit Routing Number: \_\_\_\_\_

Bank Account Number: \_\_\_\_\_

Please check account type:  Checking Account  Savings Account  Lock Box

Authorized Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail: \_\_\_\_\_

Attach a voided check or bank statement from the designated account to ensure that the request is processed accurately. Mail completed application form to the following address.

**MassHealth Dental Program  
 Attn: Provider Enrollment and Credentialing  
 12121 N. Corporate Parkway  
 Mequon, WI 53092**

*The State Treasurer is authorized to debit the account only to adjust any over-deposit that it has caused to the account. This debit would be for EFT corrections if the Commonwealth sent an erroneous EFT to the above account.*

EFT-1 (Rev. 09/05)



**Don't forget to sign above!**