



# MassHealth Dental Provider Contract for Individuals

Provider Contract between the Commonwealth of Massachusetts, acting by and through the Executive Office of Health and Human Services (hereinafter MassHealth), and

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(Legal Name of Provider, hereinafter the “Provider”)

doing business as

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(Doing Business As (DBA) Name of Provider)

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

- I. The Provider agrees:
  - A. to comply with all state and federal statutes, rules, and regulations applicable to the Provider’s participation in MassHealth.
  - B. 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).
  - C. to keep such records as are necessary to disclose fully the extent and medical necessity of the services provided to, or prescribed for, members and to preserve these records for at least six years, or for such a length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer.
  - D. 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, about any services for which payment was claimed from MassHealth, to the extent permitted or authorized by law.
  - E. to comply with 42 CFR § 455.105 by submitting, within 35 days after the date of a request by the federal Secretary of Health and Human Services or MassHealth, full and complete information about
    - 1. the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
    - 2. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.
  - F. to furnish to MassHealth its national provider identifier (NPI) if eligible for an NPI; and include its NPI on all claims.

II. MassHealth agrees:

to pay the Provider at rates set by the Massachusetts Executive Office of Health and Human Services or contained in the applicable MassHealth 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 Contract and in accordance with all applicable federal and state laws, regulations, rules, and fee schedules.

III. The Provider and MassHealth mutually agree:

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

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he or she has actual authority to bind the Provider.

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**REQUIRED ATTESTATION FOR HYGIENIST COLLABORATIVE AGREEMENT**

Not applicable (If not applicable, go to the Provider section.)

I hereby certify that I have obtained a signed collaborative agreement with a licensed Massachusetts dentist.

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Legal Name of Public Health Dental Hygienist (PHDH) Applicant

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Collaborative Dentist Name

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Collaborative Dentist License Number

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Signature of PHDH \_\_\_\_\_ Date \_\_\_\_\_

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**PROVIDER**

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(Legal Name of Provider)

By: \_\_\_\_\_ Name: \_\_\_\_\_

(Signature)

(Printed Name)

The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Do not write below this line.

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**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

By: \_\_\_\_\_ Name: \_\_\_\_\_

(Signature)

(Printed Name)

Title: \_\_\_\_\_ Date: \_\_\_\_\_