Dear Dental Clinic Applicant:

Thank you for your interest in participating in MassHealth. Enclosed is a checklist of required application documents and an enrollment packet.

Before submitting your application, you should review MassHealth's all-provider regulations (130 CMR 450.000) and all applicable program-specific regulations. You can access these regulations from the MassHealth website at www.mass.gov/masshealth-and-eohhs-regulations.

Note: Provider payment rates that are applicable to MassHealth-covered services can be accessed on the Executive Office of Health and Human Services website at www.mass.gov/masshealth-and-eohhs-regulations.

To ensure that your application is processed in a timely manner, you must return all required application documents listed on the the checklist.

Return your completed application packet to MassHealth by

Mail: DentaQuest at MassHealth Dental Program
Attn: Provider Enrollment and Credentialing
PO Box 2906
Milwaukee, WI 53201-2906

or Email: MassHealthEnrollment&Credentialing@dentaquest.com

MassHealth will notify you in writing of its decision about your application. You are not a participating MassHealth provider until you have satisfied the enrollment requirements and have been notified that your enrollment has been approved. Payment will not be made for any claims submitted for services, care, or supplies furnished before the enrollment date authorized by MassHealth.

If you have questions about or need assistance with the completion of this form, please email MassHealthEnrollment&Credentialing@dentaquest.com or call (866) 616-2699.

Sincerely,

MassHealth

Providers who participate in MassHealth are responsible for delivering crucial services to MassHealth members with disabilities and to other vulnerable populations. Providers should be aware of the Americans with Disabilities Act (ADA) and its requirements. The U.S. Department of Justice, which enforces the ADA, has issued guidelines for providers on providing individuals with mobility disabilities access to medical care. Please see www.ada.gov/ta-pubs-pg2.htm. Please review these guidelines and determine if changes to your facilities, programs, and services are necessary.

Please carefully review the following list of items that you need to include with your application. This list is designed to help ensure that your application is complete. Submitting an incomplete application may result in the delay or denial of your application. Each of these documents has been included in the application packet you received. Please note that this list is only a guide and is not intended to alter or supersede any application requirements set forth in the applicable state and federal regulations. All but two of the forms referenced on this checklist are available for download at www.mass.gov/masshealth-provider-forms.

A. ALL applicants must submit the following:

- ☐ 1. A completed Dental Provider Application (PE-DEN-DC).
- ☐ 2. A completed Federally Required Disclosures (PE-FRD-E-DEN) form. (One form for each service location listed in section 2 of the PE-DEN-DC application.)
- ☐ 3. A Massachusetts Substitute W-9 form (Refer to Tips for Completing the Massachusetts Substitute W-9 Form (APP-2) when completing this form.) MassHealth does not accept the federal W-9 form.
- ☐ 4. A signed Trading Partner Agreement (TPA).
- ☐ 5. A signed Electronic Funds Transfer Enrollment/Modification Form (EFT-1D) with required supporting documentation for authorization of electronic transfer of funds.
- ☐ 6. A signed MassHealth Dental Provider Contract for Entities (GEN-16-DEN).
- ☐ 7. If applying as a result of a merger, acquisition, closure, or change in corporate structure, include a copy of Purchase of Sale or other documentation of changes.

The Dental Clinic Provider Application (PE-DEN-DC) is available by request from www.Masshealth-Dental.org.

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PROVIDER APPLICATION

DENTAL CLINIC

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

APPLICATION TRACKING NUMBER (ATN)

Print Clear

This application will not be processed if any sections are left unanswered.

CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS APPLICATION (MassHealth may contact you if there are questions about this application.)

Name | Tel.

Email

REASON FOR APPLICATION

☐ New Enrollment ☐ Revalidation

☐ Reactivation – Provider ID service location (PID/SL) _____

☐ Adding new location (s) – Current PID _____

☐ Change of address (Please complete the grid below; the PID/SL for the old location will be terminated for a change of address.)

PID/SL of the old location	Effective date	DBA (doing business as) address of the new location

Is the application being submitted as a result of a merger, acquisition, closure, or change in corporate structure or other ownership structure? ☐ Yes ☐ No

If Yes, please describe.

SECTION 1: ORGANIZATIONAL INFORMATION

Note: The information included in Section 1 MUST apply to all service locations included in Section 2. If the information in Section 1 does not apply, a separate provider application must be completed for that service location.

1.1 ORGANIZATION TYPE

Please indicate your provider type below (select one).

☐ 11 Dental clinic

☐ 12 Dental school clinic undergraduate

☐ 13 Dental school clinic graduate

1.2 ORGANIZATION INFORMATION

Legal name of the clinic/center applicant (as reported to the Internal Revenue Service)

Legal address (address registered with Internal Revenue Service for the independent clinic/center's federal employer identification number (FEIN))

Number/street		Building, suite, or PO Box (if applicable)
City	State	Zip

ATTN/title

Email	Tel.	Fax

Ownership Class ☐ County ☐ Municipal ☐ Private, nonprofit charitable or religious ☐ Private, nonprofit, not charitable or religious ☐ State Department of Public Health ☐ State Department of Mental Health ☐ State – other ☐ For profit ☐ Unknown

Type of Entity ☐ Business corporation ☐ Government agency ☐ Nonprofit corporation ☐ Partnership ☐ Professional corporation ☐ Trust ☐ Other (describe) _____

1.3 TAXPAYER IDENTIFICATION NUMBER OF THE APPLICANT

Federal Employer Identification Number (FEIN)

1.4 MEDICAID INFORMATION FOR OTHER STATES (Attach additional pages, if necessary.)

Does the applicant currently participate, or did the applicant previously participate, in another state's Medicaid program? ☐ Yes ☐ No

List other state	Medicaid number	Effective date	End date (if applicable)
List other state	Medicaid number	Effective date	End date (if applicable)
List other state	Medicaid number	Effective date	End date (if applicable)

1.5 CRIMINAL CONVICTION(S) INFORMATION (Attach additional pages, if necessary.)

Has the applicant ever been convicted of any state or federal crime in Massachusetts or any other state in the U.S., including, but not limited to, any criminal offense relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act (i.e., Medicare, Medicaid, or CHIP)?
☐ Yes ☐ No

If Yes, provide the following information for each such conviction. Note: Convictions for criminal offenses other than offenses relating to the applicant's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act may be omitted if such conviction(s) 1) occurred more than 10 years before the date of this application, or 2) were punishable by imprisonment of less than one year, regardless of the date of such conviction.

Type of crime		
Date of conviction	Court/state	Case or record number
Type of crime		
Date of conviction	Court/state	Case or record number
Type of crime		
Date of conviction	Court/state	Case or record number

1.6 SANCTION(S) INFORMATION (Attach additional pages, if necessary.)

Has the applicant or any of its affiliated service locations ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without consent by any state (including Massachusetts) or federal agency, board, or other regulatory/licensing agency including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, remedial training, or other educational or public service activities? ☐ Yes ☐ No

If Yes, for each such action provide the following information.

Agency or board	Action taken	Date of action
Agency or board	Action taken	Date of action
Agency or board	Action taken	Date of action

1.7 PENDING PROCEEDINGS (Attach additional pages, if necessary.)

Are there any pending proceedings that could result in either a criminal conviction reportable in Section 1.5 or other sanction reportable in Section 1.6?
☐ Yes ☐ No

If Yes, provide the following information for each such proceeding.

Court/state, agency, or board	
Charge or allegation	Case or record number
Court/state, agency, or board	
Charge or allegation	Case or record number
Court/state, agency, or board	
Charge or allegation	Case or record number

1.8 BILLING ADDRESS (Address of the entity that submits claims)

If same as legal address in Section 1.2, check here. ☐ (You do not need to fill out this section.)

Number/street		Building or suite
City	State	Zip
ATTN/title		
Email	Tel.	Fax

1.9 ELECTRONIC FILE SUBMISSION METHOD

Indicate which transactions will be submitted electronically and which method will be used to transmit electronic files. (With limited exceptions, MassHealth does not accept paper claims (see 130 CMR 450.302)). You must submit a Trading Partner Agreement (TPA) if completing this section.

TRANSACTION TYPES (for groups with oral surgeon): Check the type of transaction that the applicant will be submitting or receiving. Also check who will be submitting or receiving on behalf of the applicant and how they will be submitting or receiving the transactions.

	Who is submitting/receiving?			Indicate the method being used.	
	Applicant	Practice	Vendor	DDE*	EDI**
☐ 835 Health Care Claims Payment/Advice	☐	☐	☐	☐	☐
☐ 837P Professional Health Care Claim	☐	☐	☐	☐	☐
☐ 837P COB Professional Health Care Claim For Secondary Insurers	☐	☐	☐	☐	☐
☐ 270 Health Care Eligibility Benefit Inquiry	☐	☐	☐	☐	☐
☐ 271 Health Care Eligibility Benefit Response	☐	☐	☐	☐	☐
☐ 276 Health Care Claims Status Request	☐	☐	☐	☐	☐
☐ 277 Health Care Claims Status Response	☐	☐	☐	☐	☐
☐ VOID and/or REPLACE Claims	☐	☐	☐	☐	☐

* DDE = Direct Data Entry
** EDI = Electronic Data Interchange

VENDOR INFORMATION: If you checked the "Vendor" box one or more times in the preceding "transaction types" section, you must complete this section.

Check the box that describes the vendor: ☐ Billing vendor/Provider intermediary ☐ Software vendor

In order for the vendor to submit transactions on your behalf, the vendor must also be an approved MassHealth provider with a valid MassHealth provider ID.

Vendor name	
Doing business as (DBA) name (if applicable)	
MassHealth PID/SL number (if applicable)	Vendor contact name
Vendor tel.	Vendor email

Note: Vendors must apply for a MassHealth relationship entity number before they can submit claims on behalf of the applicant. For more information, email MassHealth at EDITEAM@greatdentalplans.com

SECTION 2: SERVICE LOCATION/SATELLITE

Please list each nonenrolled service location where services will be provided to MassHealth members. Failure to do so is a violation of MassHealth regulations 130 CMR 450.222 and 450.223.

Enter the applicant trade name (DBA) and street address, national provider identifier (NPI) number, and all other information requested below, applicable to this service location where services will be provided to MassHealth members; correspondence will be mailed to this address. PO box addresses are not acceptable.
Enrollment will not be approved if a PO box address is entered in this space.

Please attach each completed copy of this page to the signed application. Each such copy shall become part of the application.

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE LOCATIONS. **NUMBER** ☐ **OF** ☐

SITE ☐ Is this a non-billing site? ☐ Yes. If Yes, provide the PID/SL of the billing site. _____ ☐ No
Please note, if this is a non-billing site, then W-9, EFT, and ERA forms are not required.

Clinic/trade/DBA name

Business address number/street | Building or suite

City | State | Zip

ATTN/title

Email | Tel. | Fax

Clinic National Provider Identifier number (NPI) | Medicare number (if applicable) | Drug Enforcement Agency (DEA) number | Controlled substance number

Clinic license number _____

HOURS OF OPERATION: Please note the current hours of operation for this business location.

MONDAY	From	To	☐ CLOSED (Check box if closed all day.)
TUESDAY	From	To	☐ CLOSED (Check box if closed all day.)
WEDNESDAY	From	To	☐ CLOSED (Check box if closed all day.)
THURSDAY	From	To	☐ CLOSED (Check box if closed all day.)
FRIDAY	From	To	☐ CLOSED (Check box if closed all day.)
SATURDAY	From	To	☐ CLOSED (Check box if closed all day.)
SUNDAY	From	To	☐ CLOSED (Check box if closed all day.)

Age range of members treated (check all that apply): ☐ Children 0-3 ☐ Children 4-20 ☐ Adults 21 and older

In the event of an emergency, do you have coverage after normal business hours or provide emergency contact information on your office phone, or have any other protocol? ☐ Yes ☐ No
If Yes, please list your contact information. Name Phone

Provide any additional after-hours coverage details.

Does the provider offer telehealth services? ☐ Yes ☐ No
If Yes, make sure that telehealth offered for MassHealth-covered services meets the requirements detailed in All-Provider Bulletin 379 at mass.gov/lists/all-provider-bulletins, or any subsequent guidance from EOHHS.

Accepting New Patients? ☐ Yes ☐ No
If No, please explain.

SECTION 3: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN.

I certify that I am duly authorized to act on behalf of the applicant including all its affiliated service locations.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments submitted on behalf of the applicant have been reviewed by me, and are true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein, and that the failure to provide true, accurate, and complete information in this provider application may result in the denial of the applicant's enrollment as a MassHealth provider or the termination of any provider agreement resulting from or related to this provider application. I understand the applicant must notify the MassHealth Dental Program of any change in the information submitted in this provider application, in accordance with and within the time specified in 130 CMR 450.223(B).

I hereby authorize MassHealth and its designees to access, and agree to furnish MassHealth upon request, any information MassHealth deems relevant to the applicant's eligibility and qualifications to be a participating provider in MassHealth. I understand and agree that the applicant has the burden to produce adequate information to MassHealth to permit evaluation of the applicant's eligibility and qualifications to be a participating provider in MassHealth, and for resolving any doubts that MassHealth may have about the applicant's eligibility and qualifications.

The applicant hereby releases from any liability MassHealth and all representatives of MassHealth for any acts performed in good faith in connection with the evaluation of the applicant's eligibility and qualifications to be a participating provider in MassHealth.

I understand that I am obligated to cooperate with MassHealth during this application process; any revalidation of enrollment (including, but not limited to, revalidation required by Section 6401 of the Affordable Care Act and occurring at least every five years); or other review process.

Printed legal name of applicant	Signature	Date

Printed legal name of individual signing on behalf of applicant	Title/relationship to applicant

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.

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If you have any questions, email MassHealthEnrollment&Credentialing@dentaquest.com; you may also call (866) 616-2699.

Send Print Clear