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

Dear 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.

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 about 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

PROVIDER ENROLLMENT CHECKLIST: DENTAL PRACTITIONER

Providers who participate in MassHealth are responsible for delivering crucial services to MassHealth members with disabilities and 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 review this guidance and determine whether changes to your facilities, programs, and services are necessary. (See www.ada.gov/ta-pubs-pg2.htm.)

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.

A. ALL applicants must submit the following:

- ☐ 1. A completed Dental Practitioner Provider Application (PE-DEN).
- ☐ 2. A signed MassHealth Dental Provider Contract for Individuals (GEN-15-DEN).
- ☐ 3. A completed Data Collection Form (POSC-DC-PE or POSC-DC-PM (for oral surgeon only)).
  It is important that MassHealth providers, trading partners, and relationship entities review and adhere to the Virtual Gateway (VG) Terms and Conditions. Each user is prompted to agree with the VG Terms and Conditions upon initial sign-in on any Commonwealth VG hosted application (e.g., MMIS). Sharing user IDs is a violation of the policy. Any user who violates the VG Terms and Conditions will be subject to termination of their user ID.
- ☐ 4. A completed Federally Required Disclosure Form for Individual Practitioners (PE-FRD-IN-DEN).

B. Individual practitioners practicing independently, and individual practitioners practicing BOTH independently AND as part of a group practice or other organization, must submit the following. Individual practitioners practicing ONLY as part of a group practice or other organization are NOT required to submit the following:

- ☐ 1. Massachusetts Substitute W-9 Form (MA-W-9). (Refer to the Tips for Completing the Massachusetts Substitute W-9 Form (APP-2) when completing this form.) MassHealth does not accept the federal W-9 Form.
- ☐ 2. An Electronic Funds Transfer Enrollment/Modification Form (EFT-1D).
  (Please include a voided check with your EFT-1D form.)
- ☐ 3. A signed Trading Partner Agreement (TPA).

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

Return your completed application packet 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

PROVIDER APPLICATION

DENTAL PRACTITIONER

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) _____

SECTION 1: APPLICANT INFORMATION

1.1 APPLICATION TYPE

Applicant enrolling as: ☐ An individual practitioner practicing independently ☐ Part of a group practice organization ☐ Both

Note: This application is for individual dental practitioners who practice independently or as part of a group practice, and who wish to enroll as a participating MassHealth dental practitioner. This application should not be completed by other salaried or contracting providers, nonbilling (ordering and referring) providers, or managed care entities (MCE).

Please indicate your provider type (select one): ☐ Dentist (PT–10) ☐ Public Health Dental Hygienist (PHDH) (PT–14)

1.2 APPLICANT INFORMATION

Legal name of applicant: Last	First	Middle initial
☐ Individual (SSN)	☐ Sole Proprietor (☐ SSN or ☐ EIN)	
Applicant's National Provider Identifier (NPI)	Date of birth (MM/DD/YYYY)	
Applicant's professional license number (MA)	State/license number	
☐ DEA number (if issued)	☐ Anesthesia license number (if issued)	
Certification in Advance Graduate Studies from a CODA Approved Specialty Program (if applicable).		
Applicant legal address/home street address		

City	State	Zip
ATTN/Title	Email	
Tel.	Fax	

1.3 MEDICAID INFORMATION FOR OTHER STATES

Does the applicant currently participate, or have they previously participated, 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)

1.4 BOARD CERTIFICATION

Check the specialty board(s) by which you are board eligible or certified, and include with your application a copy of your Certification in Advance Graduate Studies from a Commission on Dental Accreditation of the American Dental Association (CODA) Approved Specialty Program (if applicable).

☐ Orthodontics ☐ General dentistry ☐ Oral surgery ☐ Endodontics ☐ Pedodontics ☐ Periodontics
☐ Prosthodontics ☐ Geriatric dentistry ☐ Public health dental hygienist (PHDH)

1.5 HOSPITAL AFFILIATIONS

Hospital(s) at which you have admitting privileges (indicate type of privileges), if applicable.

Hospital name	
Hospital address	Hospital NPI
Type(s) of privileges	

SECTION 2: INDIVIDUAL PRACTITIONER PRACTICING INDEPENDENTLY

Note: This section applies ONLY to individual practitioners practicing independently and practitioners BOTH practicing individually AND as part of a group practice organization. If applying to participate ONLY as part of a group practice organization, please proceed to Section 3.

2.1 ELECTRONIC FILE SUBMISSION METHOD (Only for oral surgeon)

Please 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: Check the type of transaction that the applicant will be submitting and/or receiving. Also check who will be submitting and/or receiving on behalf of the applicant and how they will be submitting and/or receiving the transactions.

	Who is submitting/receiving?			Indicate the method being used.	
	Applicant	Practice	Vendor	DDE*	EDI**
☐ 837P Professional Health Care Claim	☐	☐	☐	☐	☐
☐ 270 Health Care Eligibility Benefit Inquiry	☐	☐	☐	☐	☐
☐ 271 Health Care Eligibility Benefit Response	☐	☐	☐	☐	☐

* 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 EDI@greatdentalplans.com.

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

Is the billing address the same as the legal address in Section 1.2? ☐ Yes ☐ No
If Yes, you do not have to complete the remainder of Section 2.2.

Number/street		Building, suite, or PO Box, if applicable
City	State	Zip
ATTN/title	Email	
Tel.	Fax	

2.3 SERVICE LOCATION (SL) INFORMATION (Correspondence will be mailed to this address.)

Enter the applicant's street address and all other information requested below that is applicable to this service location (SL) where services will be provided to MassHealth members. PO Box addresses are not acceptable. Enrollment will not be approved if only a PO Box address is entered in this space.

SITE A: Number/street		Building, suite (if applicable)
City	State	Zip
ATTN/title	Email	
Tel.	Fax	

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 below.

2.4 OTHER SERVICE LOCATION (SL) INFORMATION

NUMBER ☐ OF ☐

PLEASE MAKE A COPY OF SECTION 2.4 IF YOU NEED TO LIST MORE SERVICE LOCATIONS.

Note: Failure to list on the application all locations where services will be provided to MassHealth members is a violation of MassHealth regulations at 130 CMR 450.222 and 450.223. Please attach each completed copy of Section 2.4 to the signed application. Each such copy will become part of the application.

SITE B: Number/street			Building, suite (if applicable)
City		State	Zip
ATTN/title		Email	
Tel.		Fax	

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 below.

2.5 PROVIDER DIRECTORY

1. What languages, other than English, does the provider speak?

2. 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.

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

SECTION 3: GROUP AFFILIATION

NUMBER ☐ OF ☐

This section applies ONLY to applicants seeking to participate with a group practice organization currently enrolled with MassHealth or a group practice organization that is concurrently applying to enroll with MassHealth. Note: Applicants enrolling ONLY with a group practice organization do not need to submit a W-9, EFT, TPA, or ERA, as the group practice organization will be paid for services performed by the individual medical practitioner.

PLEASE MAKE A COPY OF SECTION 3 IF YOU NEED TO LIST MORE THAN FOUR GROUP AFFILIATIONS.

Please attach each completed copy of Section 3 to the signed application. Each such copy will become part of the application.

3.1 GROUP AFFILIATION

List the name(s) of each MassHealth-participating group practice organization, the NPI, and the MassHealth provider ID and service location (PID/SL). **The first group practice organization listed will serve as the primary service location.**

Group practice organization name

Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐

Group practice organization NPI	MassHealth PID/SL	
Group practice organization address (number/street)		
City	State	Zip

Group practice organization name

Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐

Group practice organization NPI	MassHealth PID/SL	
Group practice organization address (number/street)		
City	State	Zip

Group practice organization name

Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐

Group practice organization NPI	MassHealth PID/SL	
Group practice organization address (number/street)		
City	State	Zip

Group practice organization name

Check here if group practice organization enrollment is pending or is being submitted concurrently. ☐

Group practice organization NPI	MassHealth PID/SL	
Group practice organization address (number/street)		
City	State	Zip

SECTION 4: APPLICANT DISCLOSURES

4.1 CRIMINAL CONVICTION(S) INFORMATION

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.

Name of the offense		
Date of conviction	Court/state	Case or record number
Name of the offense		
Date of conviction	Court/state	Case or record number
Name of the offense		
Date of conviction	Court/state	Case or record number

4.2 SANCTION(S) INFORMATION

Has the applicant 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

4.3 PENDING PROCEEDINGS

Is the applicant subject to any proceeding(s) currently pending that could result in a conviction, sanction, or other action reportable in Sections 4.1 or 4.2?

☐ 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

4.4 UTILIZATION REVIEW

If you answer Yes to either of the following questions, please summarize comments and recommendations in section 4.5.

Have you been the subject of peer review proceedings brought by a hospital or health care facility, dental society or association, or state or federal authority?
☐ Yes ☐ No

Have you ever been sanctioned by any hospital, health care facility, or state or federal authority for practice patterns or for inappropriate or inadequate care?
☐ Yes ☐ No

4.5 ADDITIONAL EXPLANATION

The applicant may use the space below to provide additional information about their answers in Sections 4.1, 4.2, or 4.4.
Attach additional pages if necessary.

SECTION 5: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

I certify that I am a dental practitioner applying to enroll as a participating provider in MassHealth.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments 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 my enrollment as a participating provider in MassHealth or the termination of any provider agreement resulting from or related to this provider application. I understand that I must notify the MassHealth Dental Program unit of any change in any of the information submitted in this provider application, and its attachments in accordance with and within the time specified in 130 CMR 450.223(B).

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

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.

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**

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

Send Print Clear