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

Dear Dental Group Practice Organization Applicant:

Thank you for your interest in participating in MassHealth. Enclosed are an enrollment packet with the required application forms and a checklist on the reverse side for all required application documents.

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 the required forms and requested verifications. 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

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.

Please note that each individual practitioner in a group practice organization must also be individually enrolled as a provider in MassHealth. (See Section 2.4 of the Dental Group Practice Enrollment Application (PE-GPO-DEN) for a list of eligible practitioners.)

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 review these guidelines and determine if 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.

- ☐ 1. A completed Dental Group Practice Provider Application (PE-GPO-DEN).
- ☐ 2. A signed MassHealth Dental Provider Contract for Entities (GEN-16-DEN).
- ☐ 3. A completed Federally Required Disclosure Form (PE-FRD-E-DEN). (One form for each service location listed in section 2.1 of the PE-GPO-DEN application.)
- ☐ 4. 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.
- ☐ 5. A signed Trading Partner Agreement (TPA).
- ☐ 6. An Electronic Funds Transfer Enrollment/Modification Form (EFT-1D).
- ☐ 7. A completed Data Collection Form (POSC-DC-PE or POSC-DC-PM (for groups with oral surgeon(s) 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.
- ☐ 8. A completed Dental Practitioner Provider Application (PE-DEN) for each individual practitioner in the group practice organization at a service location listed in Section 2.4 of the MassHealth Dental Group Practice Organization Enrollment Application, and who is not currently enrolled with MassHealth as an individual provider.

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 GROUP PRACTICE (PT-97)

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

☐ Dental Group Practice (Provider Type 97)

1.2 GROUP PRACTICE ORGANIZATION INFORMATION

Legal name of group practice organization (also referred to as applicant as reported to the Internal Revenue Service)

Legal address (address registered with Internal Revenue Service for thegroup practice organization's Federal Employer Identification Number (FEIN))

Number/street | Building or suite

City | State | Zip

ATTN/title | Email

Tel. | Fax

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

Type of Entity: ☐ Business corporation ☐ Nonprofit corporation ☐ Partnership ☐ Professional corporation ☐ Trust ☐ Government agency
☐ Other (describe) _____ (Note: Sole proprietorship is not an eligible entity type.)

1.3 TAXPAYER IDENTIFICATION NUMBER OF GROUP PRACTICE ORGANIZATION

Federal Employer Identification Number (FEIN)

1.4 MEDICAID INFORMATION FOR OTHER STATES (Add additional pages as needed.)

Do the applicants using the tax ID listed in section 1.3 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)

1.5 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.

1.6 BILLING ADDRESS (from which the group practice organization will submit claims for services)

Is billing address same as legal address in Section 1.2 ? ☐ Yes ☐ No
If Yes, applicant need not complete remainder of Section 1.6.

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

1.7 ENTITY CRIMINAL CONVICTION(S) INFORMATION (Add additional pages as needed.)

Has the group practice organization 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 group practice's organization'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. Attach additional sheets, if necessary.

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

1.8 ENTITY SANCTION(S) INFORMATION (Add additional pages as needed.)

Has the group practice organization 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. Attach additional sheets, if necessary.

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

1.9 PENDING PROCEEDINGS (Add additional pages as needed.)

Are there any currently pending proceedings that could result in either a criminal conviction reportable in Section 1.7 or other sanction reportable in Section 1.8?
☐ Yes ☐ No.
If Yes, provide the following information for each such proceeding. Attach additional sheets, if necessary.

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

SECTION 2: SERVICE LOCATION INFORMATION

Please make a copy of Section 2 (pages 4-7) and complete for each service location (SL) where services are provided to MassHealth members.

Note: Failure to list in the application all currently nonenrolled locations where services will be provided to MassHealth members is a violation of MassHealth regulations 130 CMR 450.222 and 450.223. Please attach each completed copy of Section 2 to the signed application. Each such copy shall become part of the application. Note that each individual practitioner in a group practice organization who either renders services to MassHealth members or (for some types of practitioners) orders, refers, or prescribes services to MassHealth members must also be individually enrolled as a provider with MassHealth.

2.1 SERVICE LOCATION / "DOING BUSINESS AS" NAME

Enter the group practice's organization's trade name (SL/DBA) and street address, National Provider Identifier (NPI) number, and all other group practice organization information requested below that is applicable to this service location where services will be provided to MassHealth members. Correspondence will be mailed to this address. Enrollment will not be approved if only a post office box address is entered in this space.

SITE ☐ Group Practice's DBA name		
Group practice's number/street		Building or suite
City	State	Zip
ATTN/title	Email	
Tel.	Fax	
Group practice's Medicare number	Group practice's NPI number applicable to this service location	
Is this a non-billing site? ☐ Yes ☐ No. If Yes, provide the PID/SL of the billing site.		

Please note: if this is a non-billing site, then W-9, EFT, and ERA forms are not required.

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.

2.2 OTHER SERVICE LOCATION (SL) INFORMATION

NUMBER ☐ OF ☐

PLEASE MAKE A COPY OF SECTION 2.1 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 to the signed application. Each such copy will become part of the application.

SITE ☐ Group Practice's DBA Name

Group practice's number/street		Building or suite
City	State	Zip
ATTN/title	Email	
Tel.	Fax	
Group practice's Medicare number	Group practice's NPI number applicable to this service location	

Is this a non-billing site? ☐ Yes ☐ No. If Yes, provide the PID/SL of the billing site.

Please note: if this is a non-billing site, then W-9, EFT, and ERA forms are not required.

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.

2.3 PROVIDER DIRECTORY

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.

2.4 INDIVIDUAL PRACTITIONERS AT THIS SERVICE LOCATION (Add additional pages as needed.)

List the name(s) of each individual practitioner in the group practice organization at this service location, and the individual practitioner's NPI, MassHealth provider ID, and service location (PID/SL). A completed *Medical Practitioner Provider Application* (PE-MP-DEN) must be attached to this application for each individual practitioner in the group practice organization who will be rendering services to MassHealth members at this service location, and who is not currently enrolled with MassHealth. Also list the certified specialties that the individual practitioner identified to the respective licensing board where they obtained or renewed their license.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

For each individual practitioner, please select the type. ☐ Dentist ☐ Public health dental hygienist

Last name	First name	MI
Individual practitioner NPI	MassHealth provider ID (PID/SL) (if applicable)	

☐ Check here if individual enrollment is pending or being submitted concurrently.

SECTION 3: CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

I certify that I am duly authorized to act on behalf of the applicant.

I certify under the pains and penalties of perjury that the information on this provider application and any attachments or supplements 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 that the applicant must notify the MassHealth Dental Program of any change in the information submitted in this provider application its attachments and any applicable supplements, including any information regarding the individual practitioners listed in Section 2, in accordance with and within the time specified in 130 CMR 450.223(B).

The applicant hereby authorizes MassHealth and its designees to access, and agrees to furnish MassHealth upon request, any information MassHealth deems relevant to applicant's eligibility and qualifications to be a participating provider in MassHealth, including information about the professional performance, judgment, clinical skills, character, and ethical qualifications of the individual practitioners listed in Section 2 of this provider application that the applicant has in its possession, custody, or control, including otherwise privileged or confidential information. 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.

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