REVALIDATION ATTESTATION AND DISCLOSURES FORM
NONBILLING PROVIDER (DENTIST)
(also known as Ordering, Referring, and Prescribing Providers)

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

Please ensure that all sections of this form are completed before submission.

CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS FORM (MassHealth may contact you if there are questions about this form.)	
Name	Tel.
Email	

Section 6401 of the Affordable Care Act established a requirement for Medicare and Medicaid to revalidate enrollment information every five years for all enrolled providers, regardless of provider type (see 42 CFR § 455.414).

This form is used only for the revalidation of nonbilling providers. As defined in 130 CMR 450.212(E), a nonbilling provider is an individual provider who enrolls with MassHealth because his or her information (e.g., National Provider Identifier (NPI)) is required on a claim submitted by a billing provider to MassHealth pursuant to state or federal statute, regulation, billing instruction or other subregulatory guidance or is included on a claim because of a billing provider's own billing procedures, or is otherwise required or permitted by state or federal law to enroll with MassHealth for a limited purpose. Nonbilling providers are also known as ordering, referring, and prescribing (ORP) providers.

You should complete this form only if you are a nonbilling provider, as defined in 130 CMR 450.212(E), who received a letter from MassHealth informing you that you need to revalidate your MassHealth enrollment. As stated in that letter, you have 45 days from the date of the letter to complete and submit this form along with any other supplemental documents requested. Failure to complete revalidation by this date may result in sanctions including, but not limited to, administrative fines and suspension or termination from participation in MassHealth. (See 130 CMR 450.238 through 450.240.)

Massachusetts state law (M.G.L. c. 112 § 45) requires that dentists, as a condition of state licensure, apply to be enrolled with MassHealth as either billing providers or as nonbilling providers for the purposes of ordering, referring, and prescribing services to MassHealth members. Failure to complete your revalidation as a nonbilling provider may prevent you from renewing your Massachusetts state license at a future date.

If you are not fully licensed, and have limited license status, please attach a copy of your limited license to this form.

For additional information, including the All Provider Bulletin and the Revalidation Job Aid, please visit the MassHealth Revalidation Web Page at https://www.mass.gov/service-details/masshealth-provider-revalidation.

SECTION 1: PRACTITIONER INFORMATION

Legal Name of Practitioner		
Date of Birth	National Provider Identifier Number (NPI)	SSN
Home Street Address (Street address only, no PO boxes are allowed.)		
City	State	ZIP
Tel.	Email	
Massachusetts License Number		
Does the provider hold a license from another state? ☐ Yes ☐ No	State	License Number
State / License Number	State	License Number
DEA Number (practice state)		

☐ Check box if the DEA number is that of the primary affiliated institution*.
☐ Check box if you do not have a DEA number in your practice state
* Providers authorized to prescribe under their affiliated hospital's DEA registration number should enter that institution's DEA number.

SECTION 2: PRIMARY SERVICE LOCATION (PSL)

(All providers must complete this section. If you do not have a PSL enter your home address.)

PSL Street Address (Street address only, no PO boxes are allowed.)		
City	State	ZIP
Tel.	Fax	
Email		
Service Location Name		
MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)		

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

Street Address (Street address only, no PO boxes are allowed.)

City	State	ZIP

Tel.	Fax

Email

Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

Street Address (Street address only, no PO boxes are allowed.)

City	State	ZIP

Tel.	Fax

Email

Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

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Service Location Name

MassHealth Provider ID/Service Location (This is required only if the location is a MassHealth provider.)

SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the provider;
ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the provider or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the provider;
iii. Is an officer or director of the provider, if the provider is organized as a corporation;
iv. Is partner in the provider, if the provider is organized as a partnership;
v. Is an agent of the provider;
vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the provider or part thereof, or directly or indirectly conducts the day-to-day operations of the provider or part thereof; or
vii. Was formerly described in i through vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

The definitions applicable to this section are as follows:

- Agent means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice organization).
- Immediate family member means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- Indirect ownership interest includes an ownership interest through any other entities that ultimately have an ownership interest in the provider (e.g., an individual has a 10 percent ownership interest in the provider if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the provider).
- Member of household means, with respect to a person, any individual with whom he or she is sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.
- Ownership interest means an interest in:
  - the capital, the stock, or the profits of the provider; or
  - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the provider

☐ None (if None, continue to Section 4) ☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity			
NPI	% of Ownership (if 5% or more)		
Title, Function, or Relationship to Practitioner			
Address (Home Address if Individual; Business Address if Entity)			
City		State	ZIP
SSN (if Individual)	Date of Birth		EIN (if Entity)

*For definition and further explanation of these terms, please see the top of Section 3 above.

PLEASE MAKE A COPY OF THIS PAGE (If you need to list more than three individuals, entities, or additional addresses) NUMBER ☐ OF ☐

(All business, corporate, and PO boxes must be listed.) Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity		
NPI	% of Ownership (if 5% or more)	
Title, Function, or Relationship to Practitioner		
Address (Home Address if Individual; Business Address if Entity)		
City	State	ZIP
SSN (if Individual)	Date of Birth	EIN (if Entity)

☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity		
NPI	% of Ownership (if 5% or more)	
Title, Function, or Relationship to Practitioner		
Address (Home Address if Individual; Business Address if Entity)		
City	State	ZIP
SSN (if Individual)	Date of Birth	EIN (if Entity)

☐ Ownership/Controlling Interest (of 5% or more)* ☐ Managing Employee* ☐ Agent*

Name of Individual (Last, First, Middle Initial) or Entity		
NPI	% of Ownership (if 5% or more)	
Title, Function, or Relationship to Practitioner		
Address (Home Address if Individual; Business Address if Entity)		
City	State	ZIP
SSN (if Individual)	Date of Birth	EIN (if Entity)

*For definition and further explanation of these terms, please see the top of Section 3.

SECTION 4: DISCLOSURES

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

4A. DISCLOSURE INFORMATION

Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer "yes" to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?
☐ Yes ☐ No

2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?
☐ Yes ☐ No

3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?
☐ Yes ☐ No

4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
☐ Yes ☐ No

5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including, but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?
☐ Yes ☐ No

6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 5?
☐ Yes ☐ No

4B. ADDITIONAL EXPLANATION

If you answered Yes to any question in Section 2.B, you must provide a detailed explanation in the following space, including the name of the individual/entity; the nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

SECTION 5: CERTIFICATION STATEMENT

PLEASE READ CAREFULLY AND SIGN

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is 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.

Printed Legal Name of Provider

Signature

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.

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

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