TYPE 01 PROVIDER # 3155064 DBA NAME GORDON MARCUS TMD

Incorrect Items (Number/Area)	Absent Items (Number/Area)
General Application P 7.30.96	Spoke with Joyce Courtemanche 7.30.96 The Primary spec is OB/GYN
Eligibility Sheet	
Certification	
Provider Agreement	
GPO/BA Appt	
Attachments 1	
2	
3	
4	

DATE JUL 12 1996

Check if missing

____Articles of Organization ____Annual Report ✓ License ____Other

Date	Disposition
7.19.96	____Form letter sent requesting information
	____Telephoned provider requesting information
	____Application / Agreement / Attachments sent back for correction by provider

DEA Certificate To: Joyce Courtemanche Lynn Comm. H. C.

REV: 9/11/95

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street, Boston, Massachusetts 02111

WILLIAM F. WELD
Governor

ARGEO PAUL CELLUCCI
Lieutenant Governor

BRUCE M. BULLEN
Commissioner

DATE: July 19, 1996
Re: Marcus T. Gordon, M.D.

Dear Joyce Courtemanche,

On 7.12.96, the Provider Enrollment and Information Unit received your application for participation in the Medical Assistance Program.

We are unable to process your application because of missing or incomplete information listed below:

/✓/ License Current, Wallet Size.

/✓/ Controlled Substance Registration Certificate issued by:
United States Department of Justice
Drug Enforcement Administration, Washington, D.C.

/ / Signed Provider Agreement

/ / Other

This is to inform you that if we have not received the requested information within 30 days from the date of this letter, we will return your application without further action.

A self-addressed envelope has been included for your convenience.

If you have any questions regarding this issue, please contact me at the address shown above or at (617) 348-5385 or (800) 322-2909 (toll free in-state).

Thank you for your prompt cooperation.

Sincerely,
Rose Marie Duncan
Provider Enrollment Unit

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
William F. Weld, Governor

ISSUES THIS LICENSE TO

MARCUS T GORDON M.D.

AS A REGISTERED PHYSICIAN

REGISTRATION NO.	EXPIRATION DATE
82013	08/11/96

CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

The Controlled Substances Act of 1970 reads in part as follows:

Sec. 304. (a) A registration pursuant to section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Attorney General upon a finding that the registrant-

(1) has materially falsified any application filed pursuant to or required by this title or title III,
(2) has been convicted of a felony under this title or title III or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance; or
(3) has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances.

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	09-30-97	$210.00

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2	PRACTITIONER	94-08-31

GORDON, MARCUS T MD
38 EAST 30TH ST 7TH FLOOR
NEW YORK, NY 10016

FORM DEA-223 (7/92)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

Commonwealth of Massachusetts
Department of Public Welfare

Medical Assistance Program
Provider Application

OFFICE USE ONLY
MEDICAID PROV. NO.
3 1 5 5 0 6 4
A.C.N.
PROVIDER TYPE
0 1

1. DATE OF APPLICATION: 0 7 0 5 9 6 — 7/12/96

SECTION 1 - GENERAL INFORMATION

LEGAL ENTITY

2. TYPE	3. LAST NAME	FIRST NAME	M.I.	TITLE
1	GORDON	MARCUS	T	MD

4. NUMBER AND STREET: 110 BOYLSTON ST

5. CITY	STATE	ZIP CODE
CHESTNUT HILL	MA	02167-

6. ATTENTION LINE: ATTN

7. SOCIAL SECURITY NUMBER/FEIN	TYPE	8. LEGAL ENTITY	9. OWNERSHIP	10. CRIM. CONVIC. YES	10. CRIM. CONVIC. NO	11. EMPLOYEES/AGENTS YES	11. EMPLOYEES/AGENTS NO
	1	1	9		✓		✓

12. CHAIN YES	12. CHAIN NO	13. CHAIN NAME AND ADDRESS
	✓	

14. INTEREST YES	14. INTEREST NO	15. SUBCON. YES	15. SUBCON. NO	16. PROPERTY YES	16. PROPERTY NO

SECTION 2 - "DOING BUSINESS AS" NAME/SERVICE LOCATION ADDRESS

17. TYPE	18. LAST NAME	FIRST NAME	M.I.	TITLE
1	GORDON	MARCUS	T	MD

19. NUMBER AND STREET: 269 UNION STREET

20. CITY	STATE	ZIP CODE
LYNN	MA	01905-1314

21. ATTENTION LINE: ATTN

Commonwealth of Massachusetts
Department of Public Welfare

Medical Assistance Program
Provider Application
for

PHYSICIANS

PARAMAX: PHY-001 (REV 10/90)

SECTION 3 - ADMINISTRATION INFORMATION

22. CITY/TOWN CODE: 16300

23. AREA CODE/TELEPHONE NO.: SERVICE: 6175813900

24. AREA CODE/TELEPHONE NO.: BILLING: 6175813900

25. GROUP PRACTICE: NO ✓

26. BILLING AGENCY: YES [ ] NO [X]

SECTION 4 - CHECK MAILING AND INFORMATION MAILING ADDRESS

CHECK MAILING

27. NUMBER AND STREET: 269 UNION STREET

28. CITY: LYNN | STATE: MA | ZIP CODE: 01901-1314

29. C/O LINE: C/O

INFORMATION MAILING

30. TYPE | 31. LAST NAME | FIRST NAME | M.I. | TITLE

32. NUMBER AND STREET

33. CITY | STATE | ZIP CODE

34. ATTENTION: ATTN

SECTION 5 - ELIGIBILITY INFORMATION FOR PHYSICIANS

YOU SHOULD HAVE RECEIVED A PROVIDER MANUAL APPLICABLE TO THE PROVIDER TYPE INDICATED IN ITEM 38 AND, IF APPLICABLE, THE CERTIFIED SPECIALTIES INDICATED IN ITEM 44. IF YOU HAVE NOT RECEIVED THIS PROVIDER MANUAL, PLEASE REQUEST ONE BEFORE RETURNING THIS PROVIDER APPLICATION TO THE DEPARTMENT.

PROVIDER ELIGIBILITY INFORMATION

35. NAME: MARCUS GORDON

36. MEDICARE NO.:

37. CARRIER NAME:

38. PR. TYPE	39. LICENSE NO.	40. BOARD CODE	41. BEGIN DATE	42. END DATE	43. STATUS
01	820137	01	08 16 94	08 11 96	1

CERTIFIED SPECIALTIES

44. SPEC.	45. BOARD CODE	46. CERTIFICATION NO.	47. BEGIN DATE	48. END DATE	49. STATUS
		31269	12 07 94	12 00 04	

INDIVIDUAL PRACTITIONER SERVICE INFORMATION

INFORMATION SPECIALITIES

50. PRIM. SPEC.	51. SUB. SPEC.	52. MIDWIFE	53. SIZE	54. DEA NUMBER	54.A DEA BEGIN DATE
146	139			BG4149680	08 31 94

54.B DEA END DATE	55. LAB /X-RAY	56. N.H. PRACTICE	57. PRIM. CARE	58. ORG NPI
09 30 97	0	YES NO	YES NO	

59. UPIN NO.:

60. INST. SALARY: YES NO

	61. INSTITUTION/FACILITY NAME	62. MEDICAID PROV. NO
1.	LYNN COMMUNITY HEALTH	13018513
2.		

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF GROUP PRACTICE ORGANIZATION

GROUP PRACTICE ORGANIZATIONS

1. 1. NAME: LYNN COMM HEALTH CENTER
   2. GROUP PRACTICE NO.:
   3. EFFECTIVE DATE: 07 05 96
   4. ADDRESS: 269 Union St, Lynn, MA 01901-1614
2. 1. NAME:
   2. GROUP PRACTICE NO.:
   3. EFFECTIVE DATE:
   4. ADDRESS:
3. 1. NAME:
   2. GROUP PRACTICE NO.:
   3. EFFECTIVE DATE:
   4. ADDRESS:
4. 1. NAME:
   2. GROUP PRACTICE NO.:
   3. EFFECTIVE DATE:
   4. ADDRESS:
5. 1. NAME:
   2. GROUP PRACTICE NO.:
   3. EFFECTIVE DATE:
   4. ADDRESS:

The undersigned Provider authorizes the above-listed Group Practice Organizations to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf, in accordance with the applicable Department regulations. The Provider also authorizes the Department to issue payment checks on his/her/its behalf to the above-listed Group Practice Organizations, in accordance with applicable Department regulations.

The provider accepts full liability to the Department for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules, or regulations governing the Medical Assistance Program or the Provider's agreement with the Department, the Provider shall be fully liable to the Department as if such acts were the Provider's own acts.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of the Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Marcus Tulio Gordon — Legal name of Provider

M.D. — Title

Signature

July 5, 1996 — Date

Marcus Gordon — Typed or printed name

Medicaid Provider No.

NIA

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF GROUP PRACTICE ORGANIZATION

GROUP PRACTICE ORGANIZATIONS CONTINUED

6. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

7. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

8. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

9. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

10. 1. NAME

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS

The undersigned Provider authorizes the above-listed Group Practice Organizations to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf, in accordance with the applicable Department regulations. The Provider also authorizes the Department to issue payment checks on his/her/its behalf to the above-listed Group Practice Organizations, in accordance with applicable Department regulations.

The provider accepts full liability to the Department for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules, or regulations governing the Medical Assistance Program or the Provider's agreement with the Department, the Provider shall be fully liable to the Department as if such acts were the Provider's own acts.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of the Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Legal name of Provider _____ Title _____

Signature _____ Date _____

Typed or printed name _____ Medicaid Provider No. _____

N/A

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF BILLING AGENCY

BILLING AGENCY

1. NAME

2. BILLING AGENCY NO.

3. EFFECTIVE DATE

4. ADDRESS

The undersigned Provider authorizes the above-listed Billing Agency to submit claims to the Department of Public Welfare (hereinafter the Department) on his/her/its behalf in accordance with the applicable Department regulations. Check the following box "YES" if the provider authorizes the Department to deliver checks, made payable to the Provider, to the Billing Agency in accordance with the applicable Department regulations.

If checked yes, make sure you have entered the Billing Agency's address in the Provider Application, Section 4 - Check Mailing Address.

DELIVER	
YES	NO

The Provider warrants that he/she/it has entered into a written agreement with the Billing Agency as required by the Department's regulations. The Provider understands and agrees that his/her/its use of this Billing Agency does not in any manner relieve the Provider of full responsibility and liability for any violations by the Provider of the laws, regulations and rules which govern the Medical Assistance Program.

Moreover, the Provider accepts full liability to the Department for all actions of the Billing Agency within its actual or apparent authority to act on behalf of the Provider, not withstanding any contrary provisions in the agreement between the Provider and Billing Agency. In the case of any violations of the laws, regulations or rules governing the Medical Assistance Program which arise out of the actions of the Billing Agency, the Provider accepts full liability as though these actions were the Provider's own actions.

The Provider agrees to notify the Department at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Billing Agency shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

If the Provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

Legal name of Provider

Medicaid Provider No.

Signature

Typed or printed name

Title

Date

OFFICE USE ONLY						
MEDICAID PROV. NO.						
3	1	5	5	0	6	4
A.C.N.						

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION CERTIFICATION

PLEASE READ CAREFULLY AND SIGN

This Provider Application is an application for status as a provider in the Massachusetts Medical Assistance Program administered by the Massachusetts Department of Public Welfare. This Provider Application will become part of (and is incorporated by reference into) the Provider Agreement between this applicant and the Department of Public Welfare. The applicant should make a copy of this Provider Application for his/her/its records before submitting this copy to the Department. The Department will retain this Provider Application for its records. Moreover, the applicant should understand that he/she/it has a continuing obligation to inform the Department of any change in the information submitted on or with the Provider Application within fourteen days of the date on which the applicant becomes aware of such change.

CERTIFICATION: I have carefully reviewed this Provider Application and all attachments thereto. I certify that all information contained therein in true, accurate, and complete. If the applicant is a legal entity other than a person, the person signing this Provider Application on behalf of the applicant warrants that he/she has actual authority to do so. Signed under the pains and penalties of perjury.

Marcus Tulio Gordon
Legal name of Provider Applicant

Signature

Marcus Gordon
Printed name of signature

Physician
Title

July 5, 1996
Date

OFFICE USE ONLY
Provider Application received by Department on _____

RECEIVED
JUL 12 1996
DIVISION OF MEDICAL ASSISTANCE

Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE PROVIDER UPDATE FORM

PROVIDER NUMBER	PROVIDER NAME	PROVIDER TYPE
3 1 5 5 0 6 4	Gordon Marcus J M.D.	0 1

ACT: C

ACN:

SS/FEIN:

TYPE: 2

LEGAL ENTITY:

OWNERSHIP:

CRIMINAL CONV:

EMPLOYEE CRIM. CONV.:

CHAIN:

PARTY IN INTEREST:

SUBCONTRACTOR:

PROPERTY:

OTHER DISCL ENTITY:

ACT	SPEC CODE	SPEC CODE	BOARD CODE	CERT NUMBER	BEGIN DATE	END DATE	STATUS	BEDS	RECERT DATE

ACT: TOTAL LICENSED BEDS:

ACT: TOTAL MEDICAID BEDS:

TOTAL MEDICARE BEDS:

INFORMATION SPECIALTY DATA: ACT: PRIM. SUB

ACT: CHANGE FROM TO

ACT: CHANGE FROM TO

ACT: DEA NUMBER BEGIN DATE MM DD YY END DATE MM DD YY

MEDICAL DIRECTOR: LAST NAME FIRST NAME MI LICENSE

MGMT CONTRACT: LAST NAME FIRST NAME MI

FACILITY ADMINISTRATOR: LAST NAME FIRST NAME MI LICENSE

PROGRAM ADULT DAY HEALTH ADMIN: LAST NAME FIRST NAME MI

NUMBER OF ASSOCIATED ENTITIES: TAPE OUTPUT:

ACT: C — NONPARTICIPATING INDICATOR:

ACT: C — STATE-DISC INDICATOR:

ACT: C — COST-SETTLEMENT INDICATOR PERO (372):

ACT: PRIOR OWNER NO.:

ACT: CHANGE OF OWNER DATE:

ACT: C

BUSINESS LOCATION: NH PRACTICE: ADMIT TO PRIVATE HOSP: LAB OR XRAY: RSC:

DIRECT INDIRECT: ADMINISTERS GEN ANESTHESIA: INSTITUTE SALARY: INSTITUTE NUMBER:

AUTHORIZED SIGNATURE: [signature] DATE: 6-25-97

PROVIDER NUMBER: 3 1 5 5 0 6 4

PROVIDER NAME: Gordon, Marcus T., M.D.

OWNERSHIP

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
583 CHESTNUT STREET	LYNN

STATE	ZIP
MA	01904

ATTENTION:

DOING BUSINESS AS:

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
583 CHESTNUT STREET	LYNN

STATE	ZIP
	01904

ATTENTION:

OTHER INFORMATION

ACT	CITY/TOWN	ACT	SERVICE PHONE NUMBER	ACT	BILLING PHONE NUMBER
C	16300		6175954800		6175954800

CHECK MAILING

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
583 CHESTNUT STREET	LYNN

STATE	ZIP
	01904

ATTENTION:

INFO MAILING

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY

STATE	ZIP

ATTENTION:

	ACT			
GROUP	C			
GROUP	C			
BILLING	C			
BILLING	C			

MEDICARE NUMBER / CLIA NUMBER	C CODE	PART	BEGIN MM DD YY	END MM DD YY

UPIN NUMBER	LICENSE	BOARD CODE			STATUS	ORG

AUTHORIZING SIGNATURE: [signature]

DATE: 6.25.97

FTD ADDRESS CHANGE

An address change here changes your address on the FTD coupons only.

TEAR OFF HERE

New Address _____

_____

_____

City _____

State _____ Zip _____

Telephone Number ( ) _____

Do not write beyond this line

Form 8109-C (Rev. 10-96)

Employer Identification Number (EIN)

OMB No. 1545-0257

MARCUS GORDON M D
NORTH SHORE WOMENS CENTER
583 CHESTNUT ST
LYNN MA 01904-2600

08

INTERNAL REVENUE SERVICE CENTER
ANDOVER, MA 05501

Send FTD Address Change and correspondence to the IRS address above.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street, Boston, Massachusetts 02111

WILLIAM F. WELD
Governor

ARGEO PAUL CELLUCCI
Lieutenant Governor

JOSEPH GALLANT
Secretary

BRUCE M. BULLEN
Commissioner

Date: June 18, 1997

Provider No: 3155064

Dear Provider:

The enclosed correspondence was returned to the Division of Medical Assistance (Division) due to a change in your address. In order to ensure your continued participation in the Massachusetts Medical Assistance Program, it is essential that you notify the Division of all changes that impact your provider file.

Please supply the Division with updated address information by completing all the sections on this form. In addition, any change in address must be accompanied by a W-9 (Request for Verification of Tax Reporting Information) form. Please complete and return the enclosed W-9 form. If you have a Federal Employer Identification Number (FEIN), you must also submit a copy of a tax coupon to ensure the accuracy of the information entered in your file. The Division is not able to act on address changes that are not accompanied by a W-9 form. Please return the W-9 form and this form to the Division as soon as possible.

LEGAL ENTITY ADDRESS

MARCUS GORDON
583 Chestnut St
Lynn, MA 01904

DOING BUSINESS AS ADDRESS

North Shore Women's Center
583 Chestnut St
Lynn, MA 01904

CHECK MAILING ADDRESS

SAME

INFORMATION MAILING ADDRESS

SAME

SERVICE PHONE NO: (617) 595-4800

BILLING PHONE NO: (617) 595-4800

Signature of Provider or Designee:

Completed documents should be returned to:

Provider Enrollment Unit
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

If you have any questions, please contact the Provider Enrollment Unit at (617) 210-5500 or 1-800-322-2909 (from within Massachusetts).

PEU/Prov/Add-Change
04/97

3155064

Commonwealth of Massachusetts

Request for Verification of Taxation Reporting Information

(Massachusetts Substitute W-9 Format)

Pursuant to IRS regulations, vendors & customers must furnish their Taxpayer Identification Number *(TIN)* to the Commonwealth. Vendors must complete, sign, and return this form before payments may be made.

Name (List legal name, if joint names, list first & circle the name of the person or entity whose TIN you enter in Part 1 below. See instruction *1 if your name has been changed. MARCUS T. GORDON

Legal Address - Number & Street, (include suite or apartment number when possible) City, State and ZIP (include 9 digit Zip when available) 583 Chestnut St. Lynn, MA 01904

IF REMITTANCE (PAYMENT) ADDRESS IS DIFFERENT FROM YOUR LEGAL ADDRESS, PLEASE FILL IN BOXES PROVIDED BELOW.

Remittance Address (number & street, include suite or apt. # when possible).

Remittance City, State, ZIP(include 9 digit ZIP when available).

Phone # (617) 595-4800

PART III - TAX EXEMPT

☐ **Check if your organization is recognized by the IRS as Tax Exempt *(i.e., 501(c))?***

If claiming Tax Exempt Status, attach the IRS ruling or Determination Letter or this status will not be recognized by the Commonwealth of Massachusetts.

PART I - TIN VERIFICATION

Enter your taxpayer identification number (TIN) in the appropriate box. For individuals or sole proprietors, this is your social security number. For other entities, it is your federal employer identification number (FEI).

If vendor has more than 1 name, use Chart A for guidelines on whose TIN to enter.

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

OR

Employer Identification #

PART IV - UPDATE TO EXISTING W-9

☐ **A Request for Verification of Vendor Taxation Reporting Information has been previously filed with the Commonwealth under this TIN. This report replaces that form.**

Please attach supporting documentation specified in instructions on back of this form under Updates.

PART II - ORGANIZATION TYPE

Enter your organization type. Obtain Organization Type Letter from Chart B.

Organization Type [I]

CHART A -What Name & Number to Give the Requester

For this type of Account:	Give the name and SOCIAL SECURITY number of:
1. Individual	The individual
2. Sole Proprietorship	The owner (Show individual's name)
For this type of Account:	**Give the name and EMPLOYER IDENTIFICATION number of:**
3. A valid trust, estate, or pension trust	Legal entity (do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title)
4. Corporation	The corporation
5. Association, club, religious, charitable, or other tax-exempt organization.	The organization
6. Partnership	The partnership
7. Broker or registered nominee	The broker or nominee

CHART B - ORGANIZATION TYPE

For this type of vendor:	Type
Individual	I
Sole Proprietorship	I
Partnership	P
Trust	T
Corporation(including Mexico & Canada)	C
Other Please explain on line provided below	O

Please Type or Print

Additional Instructions are provided on the back of the form

If you selected an organizational type of "O" (Other), please explain why?

For Commonwealth vendors only: I have read and understand the Commonwealth's Tax Reporting Information (Please Check box). ☐

Under penalties of perjury, I declare that I have examined this request and to the best of my knowledge and belief, all information I have supplied is true, correct, and complete.

Signature — *Date* 6-18-97

MARCUS T. GORDON M.D. — 6-18-97

PLEASE PRINT OR TYPE YOUR NAME & TITLE — **DATE**

Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE

PROVIDER UPDATE FORM

PROVIDER NUMBER	PROVIDER NAME	
3 1 5 5 0 6 4	GORDON, MARCUS T MD	0 C

OWNERSHIP: | TYPE | LAST NAME | FIRST NAME | MI | SUFF/TTL |

STREET | CITY

STATE | ZIP | ATTENTION

DOING BUSINESS AS: | TYPE | LAST NAME | FIRST NAME | MI | SUFF/TTL |

STREET | CITY

STATE | ZIP | ATTENTION

OTHER INFORMATION: | ACT | CITY/TOWN | ACT | SERVICE PHONE NUMBER | ACT | BILLING PHONE NUMBER |

	ACT
	C

CHECK MAILING: | TYPE | LAST NAME | FIRST NAME | MI | SUFF/TTL |

STREET | CITY

STATE | ZIP | ATTENTION

INFO MAILING: | TYPE | LAST NAME | FIRST NAME | MI | SUFF/TTL |

STREET | CITY

STATE | ZIP | ATTENTION

	ACT	NUMBER	BEGIN	END
GROUP	C	9 7 8 3 2 3 7	0 4 0 2 9 8	
GROUP	C			
BILLING	C			
BILLING	C			

MEDICARE NUMBER / CLIA NUMBER	C CODE	PART	BEGIN MM DD YY	END MM DD YY

UPIN NUMBER	LICENSE	BOARD CODE	SPEC DATE	END DATE	STATUS	ORG

AUTHORIZING SIGNATURE _____ DATE 10/25/98

OFFICE USE ONLY
MEDICAID PROV. NO.
A.C.N.

Commonwealth of Massachusetts
Department of Public Welfare

MEDICAL ASSISTANCE PROGRAM
APPOINTMENT OF BILLING INTERMEDIARY:
PROVIDER APPOINTMENT OF GROUP PRACTICE ORGANIZATION

GROUP PRACTICE ORGANIZATIONS CONTINUED

6. 1. NAME: NORTH SHORE WOMENS CTR

2. GROUP PRACTICE NO.: 9783237 | 3. EFFECTIVE DATE: 04/02/98 | 4. ADDRESS:

7. 1. NAME:

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS:

8. 1. NAME:

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS:

9. 1. NAME:

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS:

10. 1. NAME:

2. GROUP PRACTICE NO. | 3. EFFECTIVE DATE | 4. ADDRESS:

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If the provider is a legal entity other than a person, the person signing this Appointment of Billing Intermediary on behalf of the Provider warrants that he/she has actual authority to do so.

North Shore Women's Centers, P.C. — Legal name of Provider

Executive Director — Title

Signature

Date

RECEIVED
MAY 08 1998
DIVISION OF MEDICAL ASSISTANCE

Marcus Gerber, MD. — Typed or printed name

3155064 — Medicaid Provider No.

PROVIDER NUMBER: 5115 5F064

PROVIDER NAME: GORDON MARCUS T MD

01

OWNERSHIP

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
1104 BOYLSTON ST	CHESTNUT HILL

STATE	ZIP	ATTENTION
MA	02467	

102

DOING BUSINESS AS:

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
480 LYNNFIELD STREET	LYNN

STATE	ZIP	ATTENTION
MA	01904	

OTHER INFORMATION

ACT	CITY/TOWN	ACT	SERVICE PHONE NUMBER	ACT	BILLING PHONE NUMBER
C		C	781/595 [illegible]	C	781/595 [illegible]

CHECK MAILING

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL

STREET	CITY
480 LYNNFIELD STREET	LYNN

STATE	ZIP	ATTENTION
MA	01904	

INFO MAILING

TYPE	LAST NAME	FIRST NAME	MI	SUFF/TTL
1	GORDON	MARCUS	T	MD

STREET	CITY
480 LYNNFIELD STREET	LYNN

STATE	ZIP	ATTENTION
MA	01904	

	ACT			END
GROUP	C			
GROUP	C			
BILLING	C			
BILLING	C			

MEDICARE NUMBER / CLIA NUMBER	C CODE	PART	BEGIN MM DD YY	END MM DD YY

UPIN NUMBER

LICENSE	BOARD CODE	BEGIN DATE	END DATE	STATUS	ORG
72013			00		

AUTHORIZING SIGNATURE [illegible] DATE 2/10/00

Commonwealth of Massachusetts | DIVISION OF MEDICAL ASSISTANCE | **PROVIDER UPDATE FORM**

PROVIDER NUMBER	PROVIDER NAME	PROVIDER TYPE
3155064	GORDON MACLAST MD	01

ACT: C

ACN:

SS/FEIN | TYPE | LEGAL ENTITY | OWNERSHIP | CRIMINAL CONV. | EMPLOYEE CRIM. CONV.

CHAIN | PARTY IN INTEREST | SUBCONTRACTOR | PROPERTY | OTHER DISCL. ENTITY

ACT	SPEC CODE	SPEC CODE	BOARD CODE	CERT NUMBER	BEGIN DATE	END DATE	STA TUS	BEDS	RECERT DATE

ACT | TOTAL LICENSED BEDS | ACT | TOTAL MEDICAID BEDS | TOTAL MEDICARE BEDS

INFORMATION SPECIALTY DATA: ACT | PRIM. | SUB

ACT | CHANGE FROM | TO

ACT | CHANGE FROM | TO

ACT: C DEA NUMBER | BEGIN DATE MM DD YY: 07 30 97 | END DATE MM DD YY: 09 30 00

MEDICAL DIRECTOR: LAST NAME | FIRST NAME | MI | LICENSE

MGMT CONTRACT | LAST NAME | FIRST NAME | MI

FACILITY ADMINISTRATOR: LAST NAME | FIRST NAME | MI | LICENSE

PROGRAM ADULT DAY HEALTH ADMIN: LAST NAME | FIRST NAME | MI

NUMBER OF ASSOCIATED ENTITIES | TAPE OUTPUT

ACT: C | NON-PARTICIPATING INDICATOR | ACT: C | STATE-ONLY INDICATOR

ACT: C | COST-SETTLEMENT INDICATOR PSRO (372) | ACT | PRIOR OWNER NO | ACT | CHANGE OF OWNER DATE

ACT: C | BUSINESS LOCATION | NH PRACTICE | ADMIT TO PRIVATE HOSP | LAB OR XRAY | RSC

DIRECT INDIRECT | ADMINISTERS GEN ANESTHESIA | INSTITUTE SALARY | INSTITUTE NUMBER

AUTHORIZING SIGNATURE KH DATE 2/6/2000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

UNITED STATES DEPARTMENT OF JUSTICE

DRUG ENFORCEMENT ADMINISTRATION

WASHINGTON, D.C. 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	09-30-2000	$210.00

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2, 2N, 3, 3N, 4, 5	PRACTITIONER	07-30-1999

* CORRECTED CERTIFICATE *
(NOT A RENEWAL)

GORDON, MARCUS T MD
480 LYNNFIELD STREET
LYNN, MA 01904

Form DEA-223 (10/96)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

IMPORTANT

If this license is lost or destroyed notify the Board of Registration in Medicine at 10 West St., Boston, MA 02111, (617) 727-3086. If your name or address is changed, you are required to notify the Board immediately in writing. Always refer to your registration number.

Registration is subject to the provisions of the General Laws and the Board's regulations. Keep this license on your person as required by law. Provide your signature where noted on the reverse.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
William F. Weld, Governor

ISSUES THIS LICENSE TO

MARCUS T GORDON M.D.
NORTH SHORE WOMEN'S CTR.
583 CHESTNUT STREET
LYNN, MA 01904
AS A REGISTERED PHYSICIAN

82013 08/11/2000

REGISTRATION NO. EXPIRATION DATE

ARGEO PAUL CELLUCCI
Governor

WILLIAM D. O'LEARY
Secretary

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street, Boston, Massachusetts 02111

Date: 2-1-2000

Provider No: 3155064

Dear Provider:

The enclosed correspondence was returned to the Division of Medical Assistance due to a change in your address. In order to ensure your continued participation in the Massachusetts Medical Assistance Program, it is essential that you notify the Division of all changes that impact your provider file.

Please supply the Division with updated address information by completing all the sections on this form. In addition, any change in address must be accompanied by a W-9 (Request for Verification of Tax Reporting Information) form. Please complete and return the enclosed W-9 form. If you have a Federal Employer Identification Number (FEIN), you must also submit a copy of a tax coupon to ensure the accuracy of the information entered in your file. The Division is not able to act on address changes that are not accompanied by a W-9 form. Please return the W-9 form and this form to the Division as soon as possible.

(HOME ADDRESS)

LEGAL ENTITY ADDRESS

480 Lynnfield Street
Lynn MA 01904

DOING BUSINESS AS ADDRESS

480 Lynnfield Street
Lynn MA 01904

(SAME AS REMIT ADDR. ON W-9)

CHECK MAILING ADDRESS

480 Lynnfield Street
Lynn MA 01904

INFORMATION MAILING ADDRESS

480 Lynnfield Street
Lynn MA 01904

SERVICE PHONE NO: (781) 595 4800 **BILLING PHONE NO:** (781) 595 4800

Signature of Provider: [signature] Marcus T. Gordon, M.D.
(Handwritten)

Completed documents should be returned to:

Provider Enrollment Unit
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

If you have any questions, please contact the Provider Enrollment Unit at (617) 210-5500 or 1-800-322-2909 (from within Massachusetts).

MARCUS T GORDON MD 3155064

Commonwealth of Massachusetts

Request for Verification of Taxation Reporting Information

(Massachusetts Substitute W-9 Format)

D MA

Pursuant to IRS regulations, vendors & customers must furnish their Taxpayer Identification Number *(TIN)* to the Commonwealth. Vendors must complete, sign, and return this form before payments may be made.

LEGAL NAME (List legal name, if joint names, list first & circle the name of the person whose TIN you enter in Part 1 below. See Specific Instructions on back page if your name has been changed).

MARCUS T. GORDON, M.D.

LEGAL ADDRESS - Number & Street, (include suite or apt# when possible) City, State and Zip (include 9 digit Zip when available)

Home 1104 Boylston St, Chestnut Hill, MA 02467

IF REMITTANCE (PAYMENT) ADDRESS IS DIFFERENT FROM YOUR LEGAL ADDRESS, PLEASE FILL IN BOXES PROVIDED BELOW.

REMITTANCE ADDRESS (number & street, include suite or apt# when possible).

480 Lynnfield Street

REMITTANCE CITY, STATE, ZIP (include 9 digit ZIP when available).

Lynn MA 01904

PHONE # (781) 595-4800

PART I - TIN VERIFICATION

Enter your Taxpayer Identification number (TIN) in the appropriate box. (Enter either *SSN* OR *EIN*. DO NOT enter both)

See CHART B

Social Security Number (SSN)

OR

Employer Identification Number (EIN)

PART II - ORGANIZATION TYPE

Enter your organization type. Obtain Organization Type Letter from Chart B

Organization Type: I

PART III TAX - EXEMPT

☐ Check if your organization is recognized by the IRS as Tax Exempt *(i.e., 501(c))?*

If claiming Tax Exempt Status, attach the IRS ruling or Determination Letter or this status will not be recognized by the Commonwealth of Massachusetts.

PART IV - UPDATE TO EXISTING W-9

☐ A Request for Verification of Taxation Reporting Information has been previously filed with the Commonwealth under this TIN. This report replaces that form.

Please attach supporting documentation specified in instructions on back of this form under Updates.

CHART A - WHAT NAME TO GIVE THE REQUESTER

For this type of Account:	Give the Name and SSN OR EIN
☐ Individual	The individual - SSN ONLY
☐ Sole Proprietorship	The owner (Show individual's name) SSN or EIN
For this type of Account:	**Give the Name and Employer Identification Number of:**
☐ A valid trust, estate, or pension trust	Legal entity (do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title).
☐ Corporation	The corporation
☐ Association, club, religious, charitable, or other tax-exempt org.	The organization is associated with Other in CHART B
☐ Partnership	The partnership
☐ Broker or registered nominee	The broker or nominee

CHART B - ORGANIZATION TYPE

For this type of vendor:	Type
Individual - SSN	I
Sole Proprietorship - SSN or EIN	I
Partnership - EIN	P
Trust - EIN	T
Corporation (including Mexico & Canada) - EIN	C
Other - EIN *Please explain on line provided below.*	O

Additional instructions are provided on the back of this form.

If you select an organization type of "O" (Other), please explain why?

I have read and understand the Commonwealth's Tax Reporting Information *(Please check box).* ☑

Under penalties of perjury, I declare that I have examined this request and to the best of my knowledge and belief, all information I have supplied is true, correct, and complete.

Signature — 2,04,00 *Date*

Marcus Gordon, M.D. — *Please print or type your name & title*

2,04,00 *Date*

Commonwealth of Massachusetts DIVISION OF MEDICAL ASSISTANCE **PROVIDER UPDATE FORM**

PROVIDER NUMBER 3 1 5 5 0 6 4 | PROVIDER NAME GORDON MARCUS T MD | TYPE 01

ACT C | AGR

SS/FEIN | TYPE | LEGAL ENTITY | OWNERSHIP | CERTIFICATE OWN. | EMPLOYEE CERT. OWN.

CHAIN | PARTY IN INTEREST | SUBCONTRACTOR | PROPERTY | OTHER RELATED ENTITY

ACT	SPEC CODE	SPEC CODE	BOARD CODE	CERT NUMBER	BEGIN DATE	END DATE	DATA SOURCE	BEDS	RECERT DATE

ACT	TOTAL LICENSED BEDS	ACT	TOTAL MEDICAID BEDS	TOTAL MEDICARE BEDS

INFORMATION SPECIALTY DATA: ACT | PRIM. | SUB

ACT | CHANGE FROM | TO

ACT | CHANGE FROM | TO

ACT | DEA NUMBER | BEGIN DATE MM DD YY | END DATE MM DD YY

MEDICAL DIRECTOR | LAST NAME | FIRST NAME | MI | LICENSE

MGMT CONTRACT | LAST NAME | FIRST NAME | MI

FACILITY ADMINISTRATOR | LAST NAME | FIRST NAME | MI | LICENSE

PROGRAM ADULT DAY HEALTH ADMIN | LAST NAME | FIRST NAME | MI

NUMBER OF ASSOCIATED ENTITIES | TAPE OUTPUT

ACT C | [redacted] | ACT C | [redacted]

ACT C | COST SETTLEMENT INDICATOR PERO 3372 | ACT | PRIOR OWNER NO. | ACT | CHANGE OF OWNER DATE

ACT C | BUSINESS LOCATION | NH PRACTICE | ADMIT TO PRIVATE HOSP | LAB OR XRAY | RSC

DIRECT - INDIRECT | ADMINISTERS GEN ANESTHESIA | INSTITUTE SALARY | INSTITUTE NUMBER

AUTHORIZING SIGNATURE K H DATE 3-9-16

MARCUS T GORDON 3155064

Commonwealth of Massachusetts

Request for Verification of Taxation Reporting Information D MA

(Massachusetts Substitute W-9 Format)

Pursuant to IRS regulations, vendors & customers must furnish their Taxpayer Identification Number *(TIN)* to the Commonwealth. Vendors must complete, sign, and return this form before payments may be made.

LEGAL NAME (List legal name, if joint names, list first & circle the name of the person whose TIN you enter in Part 1 below. See Specific Instructions on back page if your name has been changed).

MARCUS T. Gordon, M.D.

LEGAL ADDRESS - Number & Street, (include suite or apt# when possible) City, State and Zip (include 9 digit Zip when available)

Home 1104 Boylston St, Chestnut Hill, MA 02467

IF REMITTANCE (PAYMENT) ADDRESS IS DIFFERENT FROM YOUR LEGAL ADDRESS, PLEASE FILL IN BOXES PROVIDED BELOW.

REMITTANCE ADDRESS (number & street, include suite or apt# when possible).

480 Lynnfield Street

REMITTANCE CITY, STATE, ZIP (include 9 digit ZIP when available).

Lynn MA 01904

PHONE # (781) 595-4800

PART I - TIN VERIFICATION

Enter your Taxpayer Identification number (TIN) in the appropriate box. (Enter either *SSN* OR *EIN*. DO NOT enter both)

See CHART B

Social Security Number (SSN)

OR

Employer Identification Number (EIN)

PART II - ORGANIZATION TYPE

Enter your organization type. Obtain Organization Type Letter from Chart B

Organization Type: I

PART III TAX - EXEMPT

☐ Check if your organization is recognized by the IRS as Tax Exempt *(i.e., 501(c))?*

If claiming Tax Exempt Status, attach the IRS ruling or Determination Letter or this status will not be recognized by the Commonwealth of Massachusetts.

PART IV - UPDATE TO EXISTING W-9

☐ A Request for Verification of Taxation Reporting Information has been previously filed with the Commonwealth under this TIN. This report replaces that form.

Please attach supporting documentation specified in instructions on back of this form under Updates.

CHART A - WHAT NAME TO GIVE THE REQUESTER

For this type of Account:	Give the Name and SSN OR EIN
☐ Individual	The individual - SSN ONLY
☐ Sole Proprietorship	The owner (Show individual's name) SSN or EIN
For this type of Account:	**Give the Name and Employer Identification Number of:**
☐ A valid trust, estate, or pension trust	Legal entity (do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title).
☐ Corporation	The corporation
☐ Association, club, religious, charitable, or other tax-exempt org.	The organization is associated with Other in CHART B
☐ Partnership	The partnership
☐ Broker or registered nominee	The broker or nominee

CHART B - ORGANIZATION TYPE

For this type of vendor:	Type
Individual - SSN	I
Sole Proprietorship - SSN or EIN	I
Partnership - EIN	P
Trust - EIN	T
Corporation (including Mexico & Canada) - EIN	C
Other - EIN *Please explain on line provided below.*	O

Additional instructions are provided on the back of this form.

If you select an organization type of "O" (Other), please explain why?

I have read and understand the Commonwealth's Tax Reporting Information *(Please check box).* ☑

Under penalties of perjury, I declare that I have examined this request and to the best of my knowledge and belief, all information I have supplied is true, correct, and complete.

Signature — 2,04,00 *Date*

Marcus Gordon, M.D. — *Please print or type your name & title*

2,04,00 *Date*

Med Advantage

Verification Status for: **Gordon, Marcus T, MD**
North Shore Womens Ctr
480 Lynnfield Street
Lynn, MA 01904

MassHealth (Group B)
April 22, 2008

Action Inquiries

Inquiry Type	Verified?	Source	Date Verified	Verified By
DHHS	Yes	NPDB and/or HIPDB	01/17/2008	DHevron
HIPDB	Yes	Clear	01/17/2008	DHevron
NPDB	Yes	Report	03/19/2008	RVolpe

Action(s)/Sanction(s)*

NONE

Certification(s)

Board ID/ Cert#	Verified?	Issue Date	Expiration	Source	Date Verified	Verified By
ABMS: OBG	Yes	12/09/1994	12/31/2011	ABMS 4Q/07	02/21/2008	ARiggins
DEA: BG4149680	Yes		09/30/2009	NTIS Feb/08	02/20/2008	GMcshea
STMA: 82013	Yes	09/27/1995	08/11/2008	MAWH/2008	04/10/2008	Admin
STMACDS: MG0277625A	Yes	07/14/2006		Cert	02/28/2008	MKessinger

Education

Degree	Verified?	From	To	Source	Date Verified	Verified By
M.D.	Yes		06/30/1985	AMA 4Q/00	01/26/2001	PMurphy
Albert Einstein College of Medicine: Bronx NY						
Internship - S	Yes	07/01/1985	06/30/1986	AMA 4Q/00	01/26/2001	PMurphy
Bronx Municipal Hospital: Bronx NY						
Residency - OBG	Yes	07/01/1988	10/31/1990	AMA 4Q/00	01/26/2001	PMurphy
Boston Medical Center: Boston MA						

Group(s)

Name	Verified?	Source	Date Verified	Verified By
Aetna HMO1	No			
Aetna Inc.	No			
Blue Cross Blue Shield of Massachusetts	No			
CIGNA	No			
Harvard Pilgrim Health Care	No			
Neighborhood Health Plan	No			
Tufts Health Plan	No			

Verification Status for:

Gordon, Marcus T, MD
North Shore Womens Ctr
480 Lynnfield Street
Lynn, MA 01904

MassHealth (Group B)
April 22, 2008

Insurance

Insurance ID	Verified?	Policy #	Expiration	Source	Date Verified	Verified By
PM	Yes	1-23186	01/22/2009	DEC pg	04/21/2008	MPerez

Litigation/Claim(s)*

Litigant	Verified?	Source	Date Verified	Verified By
	Yes	Report	03/19/2008	RVolpe

Privilege(s)/Delineation

Hospital	Verified?	Primary	Source	Date Verified	Verified By
North Shore Medical Center	Yes	Yes	Ltr	08/28/2007	MCarrasquillo

Reference(s)

Work History

Company	Verified?	From	To	Source	Date Verified	Verified By
North Shore Womens Ctr	No	04/01/1997	Present			

Verification Status for: **Gordon, Marcus T, MD**
North Shore Womens Ctr
480 Lynnfield Street
Lynn, MA 01904

MassHealth (Group B)
April 22, 2008

Verification Sources

DEA - Drug Enforcement Administration

STMA - Massachusetts Board of Registration

STMACDS - State Of Massachusetts - CDS Certificate

ABMS - The board certification(s) contained in this report has been primary source verified against the ABMS Database.

AMA - ©1998 by the American Medical Association

MAWH/2008 - Med Advantage Data Warehouse

* Sanctions are verified from the NPDB and/or State Licensing agency(s) at the same time License is verified.

* Litigations are verified from the NPDB and/or the Insurance Carrier(s) at the same time insurance is verified.

Med Advantage (CVO)
11301 Corporate Blvd., Suite 300 Orlando, Florida 32817
(407) 282-5131

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

165025

DCN: **5500000050289990**
Process Date : 03/19/2008
Page : 1 of 1
GORDON, MARCUS T
For authorized use by :
MassHealth (Group B)

NPDB QUERY RESPONSE

A. SEARCH RESULT

Based on the subject identification information provided by you in Section B below, a search of the NPDB has located the following 1 report(s):

Type of Report(s)	Report Number(s)
MEDICAL MALPRACTICE PAYMENT REPORT(S):	5500000016823229

Recipients should verify that the subject identified in Section B is, in fact, the subject of interest.

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	GORDON, MARCUS T
Gender:	MALE
Date of Birth:	*08/11/1959*
Other Name(s) Used:	
Organization Name:	
Organization Type:	
Work Address:	480 LYNNFIELD STREET
City, State, Zip:	LYNN, MA 01904
Home Address:	
City, State, Zip:	
Social Security Numbers(SSN):	
Individual Taxpayer Identification Numbers (ITIN):	
Professional School(s) and Year of Graduation:	ALBERT EINSTEIN COLLEGE OF MEDICINE 1985
Occupation/Field of Licensure(Code):	Physician (MD) (010)
State License Number, State of Licensure:	82013 , MA
Specialty:	
Drug Enforcement Administration (DEA) Numbers:	
National Provider Identifiers (NPI):	
Federal Employer Identification Numbers (FEIN):	
Unique Physician Identification Numbers (UPIN):	

C. ENTITY INFORMATION

Data Bank Identification Number (DBID):	399700000091597
Entity Name:	**MassHealth (Group B)**
Authorized Agent:	MED ADVANTAGE
Authorized Submitter's Name:	JOHN WITTY
Authorized Submitter's Title:	AGENT
Authorized Submitter's Telephone:	(407) 282-5131

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

165025

DCN: 5500000016823229
Process Date: 04/07/2000
Page: 1 of 3
For authorized use by:
MassHealth (Group B)

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number: 5500000016823229

This report is maintained in: [X] The National Practitioner Data Bank

[ ] The Healthcare Integrity and Protection Data Bank

This report is maintained by the NPDB for restricted use under the provisions of Title IV of Public Law 99-660, as amended; and 45 CFR Part 60.

All information is confidential and may be used only for the purpose for witch it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: MEDICAL LIABILITY MUTUAL INSURANCE COMPA
Address: 2 PARK AVENUE

City, State, ZIP: NEW YORK, NY 10016

Entity Internal Report Reference (e.g., claim number):

Name or Office: JAMES ROBB
Title or Department: VICE PRESIDENT
Telephone: 2125769850

Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: GORDON, MARCUS TULIO
Other Name(s) Used:
Gender: MALE

Organization Name: MARCUS T. GORDON, MD
Address: 1101 BOYLSTON STREET

City, State, Zip: CHESTNUT HILL, MA 02167
Country:

Home Address:

City, State, Zip:
Country:

Date of Birth: 08/11/1959

Social Security Number:

Professional School(s) and Year(s) of Graduation: ALBERT EINSTEIN MEDICAL COLLEGE 1985

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

165025

DCN: 5500000016823229
Process Date: 04/07/2000

For authorized use by:
MassHealth (Group B)

Occupation/Field of Licensure (Code): Physician (MD) (010)

State License Number, State of Licensure: 168240 , NY

Drug Enforcement Administration (DEA) Numbers:

Hospital Affiliation(s): ST. LUKES-ROOSEVELT HOSPITAL
NEW YORK, NY

BETH ISRAEL HOSPITAL
NEW YORK, NY

C. INFORMATION REPORTED

Date of Report: 04/07/2000

Act/Omission Code: Treatment: Not Otherwise Classified (690)

Earliest date act or omission occurred: 07/13/1994

Last date act or omission occured:

Payment Date: 04/04/2000

Multiple or Single Payment: SINGLE PAYMENT

Amount of this Payment: $160,000.00

Total Amount of Judgement or Settlement: $180,000.00

Payment Result of: SETTLEMENT

Number of Practitioners For Whom Payment Is Made: 1

Relationship of Entity to the Practitioner: INSURANCE COMPANY

Date of Judgment/Settlement: 03/07/2000

Adjudicative Case Number: 8661/95

Adjudicative Body Name: SUPREME COURT OF THE STATE OF NY CO OF BRONX

Court File Number:

Reporter's Description of the Act or Omission: 1-65448-M A THEN 28 YEAR OLD FEMALE DEVELOPED EITHER OSTEOMYELITIS OR OSTEITIS PUBIS FOLLOWING C-SECTION. THE PATIENT REFUSED TO HAVE A BONE PUNCTURE WHICH WOULD CONFRIM HER DIAGNOSIS.

Reporter's Description of the Judgment or Settlement: CASE SETTLED FOR $160,000.00 ON BEHALF OF DR. GORDON OUT OF A TOTAL $180,000.00

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

165025

DCN: 5500000016823229
Process Date: 04/07/2000
Page: 3 of 3
For authorized use by:
MassHealth (Group B)

E. REPORT STATUS

An "X" indicates that the information in this report has been

☐ Disputed by the subject identified in Section B.

☐ Elevated for decision by the Secretary of the U.S. Department of Health and Human Services. – Pending

☐ Reviewed by the Secretary of the U.S. Department of Health and Human Services, who has made the following comment concerning the report:

Date of Initial Report: 04/07/2000

Date of Most Recent Change: 04/07/2000

F. SUPPLEMENTAL SUBJECT INFORMATION ON FILE WITH DATA BANKS

The following Information was not provided by the reporting entity Identified in section A of this report. The Information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.

END OF REPORT

165025
DE 134283

NSMC
NORTH SHORE MEDICAL CENTER

81 Highland Avenue Salem, MA 01970 P: 978-354-2020 F: 978-354-3963

8/28/2007

Med Advantage

To Whom It May Concern:

The following is in response to your request for information and is provided to you in lieu of completion of the evaluation form you submitted. The information is based upon review of the practitioner's file, and should provide the necessary documentation. The individual listed below has been fully credentialed at our Hospital in accordance with Massachusetts Law 243CMR 3.05.

Username

Practitioner name	Gordon, Marcus Tulio, MD		
Department	Obstetrics & Gynecology	**Section**	
Current status	Current		
Status category	Active		
Dates on Staff	07/22/1997		
Next reappt date	08/31/2009		
Admitting Privileges	Yes		
Clinical Skills	Dr. Gordon continues to meet/or had continued to meet all clinical performance and health requirements to qualify for reappointment at our Hospital,		
Disciplinary Action	None (As defined in 243 CMR 3.02		
Liability Claims:	Please refer to application for licensure (Massachusetts Board of Registration in Medicine) or to malpractice claims of loss history.		

If you require further information, please contact the Medical Staff Office Department at 978-354-2020.

Lenora Salvucci

Medical Staff Coordinator 8/28/2007

NSMC - North Shore Medical Center (Merger of Salem and Union Hospital as of March 1, 2004.

165025

ProMutualGroup®

Medical Professional Mutual Insurance Company

EN 275692(1

Medical Professional Liability - Occurrence Renewal Declaration

POLICY NUMBER: 1-23186
FORMER POLICY NUMBER: 1-23186

NAMED INSURED AND ADDRESS:
Marcus T. Gordon, M.D.
1101 Boylston Street
Chestnut Hill, MA 02167

PMG ID#: A7616

PRODUCER:
HUB International New England, LLC
299 Ballardvale St
Wilmington, MA 01887-1080
Phone: 978-657-5100

PRODUCER ID#: G20J086

POLICY PERIOD: 01/22/2008 to 01/22/2009 at 12:01 A.M. Standard Time at Named Insured address above.

DESCRIPTION OF BUSINESS:
SOLO CORPORATION

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE COVERAGE STATED IN THIS POLICY.

*****THE POLICY SHALL NOT BE EFFECTIVE UNLESS THE FIRST INSTALLMENT PAYMENT*****
*****IS RECEIVED ON OR BEFORE THE DUE DATE DISPLAYED ON THE INVOICE.*****

COVERAGE	RETROACTIVE DATE	SPECIALTY/CLASSIFICATION	LIMIT OF LIABILITY	
Professional Liability		80167 Gynecology-Major Surgery	$1,000,000	Per Claim
			$3,000,000	Aggregate
Occurrence				
Supplementary Payments Retroactive Date:	01/01/1998			

ADDITIONAL RATING FACTORS:

Claims Free Credit
Vicarious Liability Charge for Employed Practitioners

ADDITIONAL COVERAGES: **PREMIUM:**

FORMS AND ENDORSEMENTS ATTACHED TO THIS POLICY:

PL 024 09/05	Medical Professional Liability for Physicians and Surgeons – Occurrence Form
PL 054 02/06	Massachusetts Mandatory Amendments Endorsement

POLICY PREMIUM: **$47,500**

Richard W. Brewer
President & CEO

Janice W. Allegretto
Asst. Sec.

THIS IS NOT A BILL. THE BILL WILL FOLLOW SHORTLY.

Office Information: Please list **all** office addresses. Indicate which office is your primary office (only one office can be noted as your Primary Office), and which should be your mailing address. Also, please indicate if this particular address is your administrative, clinical or research office.

	Office Type	
Office/Practice Name: North Shore Womens Center Practice Manager Name: Stephanie Lowitt Street Address: 480 Lynnfield St. Street Address: City: Lynn State: MA Zip: 01904 If not currently at this site, expected start date: OFFICE PHONE #: 781 595 4800 OFFICE FAX #: 781 595 3843	Mailing Address: YES ☒ NO ☐ ☒ Primary Practice Address ☐ Administrative Address ☐ Other Clinical Practice Office ☐ Research Office	
Office/Practice Name: Merrimack Valley Womens Health Services Practice Manager Name: Stephanie Lowitt Street Address: 9 Branch St. Street Address: City: Methuen State: MA Zip: 01844 If not currently at this site, expected start date: OFFICE PHONE #: 978 688 7222 OFFICE FAX #: 978 688 7236	Mailing Address: YES ☐ NO ☒ ☐ Primary Practice Address ☐ Administrative Address ☒ Other Clinical Practice Office ☐ Research Office	
Office/Practice Name: Four Women Physician Group Practice Manager Name: Stephanie Lowitt Street Address: 150 Emory St. Street Address: City: Attleboro State: MA Zip: 02703 If not currently at this site, expected start date: OFFICE PHONE #: 508 222 7555 OFFICE FAX #: 508 226 2218	Mailing Address: YES ☒ NO ☐ ☐ Primary Practice Address ☐ Administrative Address ☒ Other Clinical Practice Office ☐ Research Office	

Board Certification: (Please list both specialty and sub-specialty board certification)

Board Name: American Board of Obstetrics and Gynecology
Specialty:
Date of Initial Certification: 1994 Valid Through: 2004 Date Re-certified: 6/27/05

Board Name:
Specialty:
Date of Initial Certification: Valid Through: Date Re-certified:

Board Name:

Specialty: ____

Date of Initial Certification: ____ Valid Through: ____ Date Re-certified: ____

If you are not Board Certified, are you eligible for Board admission? Yes ☐ No ☐ If you are not Board Certified, please indicate the date that you plan to sit for the Board exam or confirm that you received your medical training prior to when the Board was offered.

____. If

you are Board Eligible and do not plan to sit for the Boards please explain why: ____

____

Education: In chronological order, list all schools you have attended beyond high school. Attach additional sheet if necessary. *Please provide* **complete** mailing addresses.

College/University: Cheyney State College
Street: 1837 University Cir. City: Cheyney State: PA Zip: ____
Country: USA Degree: Psychology From: 09/ /1977 To: 01/ /1978

College/University: City College of New York
Street: 135 th St & Convent Ave City: New York State: NY Zip: 10031
Country: USA Degree: Psych / Biochem From: 01/ /1978 To: 06/ /1981
1 2

College/University: Albert Einstein College of medicine
Street: 1300 morris park Ave City: Bronx State: NY Zip: 10461
Country: U.S.A. Degree: MD From: 09/ /1981 To: 06/ /1985

Internship: **Include only primary hospital (do not include rotations).** Attach additional sheet if necessary:

Hospital/Facility: Montefiore Hospital and medical Ctr.
Street: ____ City: Bronx State: NY Zip: ____
Department/Specialty: Surgery Dates (Mo/Yr) From: ____ To: ____
Supervisor/Chief/Contact Person: Dept Chair Phone Number: ____

Residencies: **Include only primary hospital (do not include rotations).** *Attach additional sheet if necessary.*

Hospital/Facility: Boston City Hospital
Street: 715 Albany st City: Boston State: MA Zip: 02118
Department/Specialty: OB/GYN Dates (Mo/Yr) From: ____ To: ____
Supervisor/Chief/Contact Person: Dept Chair Phone Number: 617 638 6500

Hospital/Facility: ____

Fellowships: Include only primary hospital (do not include rotations). Attach additional sheet if necessary.

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Professional Affiliations/ Work History: List **all** healthcare facilities, both current and prior, (i.e., hospitals, health centers, medical groups, clinics, military facilities, etc.) with which you have been affiliated for the purpose of providing patient care. **Do not list internships, residences or fellowships that you noted on previous pages - please include any moonlighting.** Please use additional sheets if necessary. List most recent affiliations first. Please indicate your primary Hospital.

Primary Hospital ☐
Hospital/Facility: North Shore Womens Ctr Reason for Discontinuance: Current
Street: 4180 Lynnfield St. City: Lynn State: MA Zip: 01904
Department/Specialty: Gyn Staff Category: Physician
Supervisor/Chief: _____ Dates (Mo/Yr) From 4/97 To present Admitting Privileges: Yes ☑ No ☐

Primary Hospital ☒
Hospital/Facility: North Shore Medical Ctr Reason for Discontinuance: Current
Street: 81 Highland Ave City: Salem State: MA Zip: 01970
Department/Specialty: Gyn Staff Category: physician/surgeon
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To present Admitting Privileges: Yes ☑ No ☐

Primary Hospital ☐
Hospital/Facility: Merrimack Valley Womens Health Services Reason for Discontinuance: Current
Street: 9 Branch St. City: Methuen State: MA Zip: 01844
Department/Specialty: Gyn Staff Category: physician
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To present Admitting Privileges: Yes ☐ No ☐

►►► **Please provide an explanation of any gaps in your professional career.** ◄◄◄
Continue on an attached sheet if you have more affiliations than space allows.

Fellowships: **Include only primary hospital (do not include rotations).** Attach additional sheet if necessary.

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Professional Affiliations/ Work History: List all healthcare facilities, both current and prior, (i.e., hospitals, health centers, medical groups, clinics, military facilities, etc.) with which you have been affiliated for the purpose of providing patient care. **Do not list internships, residences or fellowships that you noted on previous pages - please include any moonlighting.** Please use additional sheets if necessary. List most recent affiliations first. Please indicate your primary Hospital.

Primary Hospital ☐
Hospital/Facility: Four Women physician Group Reason for Discontinuance: Current
Street: 150 Emory St. City: Attleboro State: MA Zip: 02703
Department/Specialty: Gyn Staff Category: Physician
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To present Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐
Hospital/Facility: Planned Parenthood of MA Reason for Discontinuance: Current
Street: _____ City: _____ State: MA Zip: _____
Department/Specialty: Gyn Staff Category: physician
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To present Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐
Hospital/Facility: Center for Comprehensive Health Practice Reason for Discontinuance: _____
Street: 163 E. 97th St. City: New York State: NY Zip: 10016
Department/Specialty: OB/GYN Staff Category: OB/GYN
Supervisor/Chief: _____ Dates (Mo/Yr) From 5/94 To 5/95 Admitting Privileges: Yes ☐ No ☐

►►► **Please provide an explanation of any gaps in your professional career.** ◄◄◄
Continue on an attached sheet if you have more affiliations than space allows.

Fellowships: Include only primary hospital (do not include rotations). Attach additional sheet if necessary.

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____
Supervisor/Chief/Contact Person: _____ Phone Number: _____

Professional Affiliations/ Work History: List **all** healthcare facilities, both current and prior, (i.e., hospitals, health centers, medical groups, clinics, military facilities, etc.) with which you have been affiliated for the purpose of providing patient care. **Do not list internships, residences or fellowships that you noted on previous pages - please include any moonlighting.** Please use additional sheets if necessary. List most recent affiliations first. Please indicate your primary Hospital.

Primary Hospital ☐
Hospital/Facility: Eastern Womens Ctr. Reason for Discontinuance: _____
Street: 38 E. 30th St. City: New York State: NY Zip: 10016
Department/Specialty: OB/Gyn Staff Category: _____
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To _____ Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐
Hospital/Facility: _____ Reason for Discontinuance: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Staff Category: _____
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To _____ Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐
Hospital/Facility: _____ Reason for Discontinuance: _____
Street: _____ City: _____ State: _____ Zip: _____
Department/Specialty: _____ Staff Category: _____
Supervisor/Chief: _____ Dates (Mo/Yr) From _____ To _____ Admitting Privileges: Yes ☐ No ☐

►►► **Please provide an explanation of any gaps in your professional career.** ◄◄◄
Continue on an attached sheet if you have more affiliations than space allows.

Statement of Continuing Medical Education Credits: (please list the courses taken in the last 24 months. Your education activities should relate, at least in part, to your privileges.)

Course Taken:	Where:	When:	# of CME hours:
Annual Meeting Med Track	Nat Conference Boston MA	April 21-24, 07	13
Post Grad Seminar	"	"	6

Military Commitment:

Branch of Service:	
Duty Status:	
Rank:	
Present Duty Assignments:	
☐ **I have no military obligations**	

Licensure: Please list all professional licenses that you currently hold or have held in any jurisdiction.

Current Licenses:

Number	State	Expiration Date	Type (full, limited, temporary)
82013	MA	8/11/08	Full

Previous Licenses:

Number	State	Expiration Date	Type (full, limited, temporary)

Life Support Certifications: As applicable please list any life support certificates you may have

	Number, if applicable	State, if applicable	Expiration Date	Type
Basic Life Support (BLS) CPR		MA	11/2007	AHA (BLS)
Adv Cardiac Life Support (ACLS)				
Pediatric Adv Life Support (PALS)				
Neonatal Adv Life Support (NALS)				
Adv Trauma-Life Support (ATLS)				

Massachusetts Controlled Substance Registration Certificate - Registration Number: _____ Issue Date: 7/14/06

Federal Drug Enforcement Administration (DEA) Certificate Registration Number: _____ Exp. Date: 9/30/09

National Practitioner Identification Number (NPI): 1013925569

If you have Medicare, Medicaid and UPIN numbers please list them below:

MA. Medicare ID #: A21704 MA. Medicaid ID #: 3155064 UPIN #: _____

Do you participate in and meet the conditions of participation in Medicare? Yes ☒ No ☐

Professional References: Please check with the individual Hospital/Health Plan to which you are applying for specific instructions regarding the submission of Professional References.

Contact Name: _____ Contact Title: _____
Hospital/Facility: _____ Department: _____ Phone Number: (___) _____
Street: _____ City: _____ State: _____ Zip: _____ Country: _____

Contact Name: _____ Contact Title: _____
Hospital/Facility: _____ Department: _____ Phone Number: (___) _____
Street: _____ City: _____ State: _____ Zip: _____ Country: _____

Contact Name: _____ Contact Title: _____
Hospital/Facility: _____ Department: _____ Phone Number: (___) _____
Street: _____ City: _____ State: _____ Zip: _____ Country: _____

Professional Liability Insurance: List names, complete addresses, policy numbers, dates of coverage and limits of liability for **all liability insurance carriers** including self-insured institutions and including internship and residency programs for the past 10 years. Please attach additional sheets, if necessary. List most recent carriers first.

Name of Company: Pro mutual Group
Street: 299 Ballardvale St. City: Wilmington State: MA Zip: 01887
Policy Number: 1-23186 Dates of Coverage (Mo/Yr) From: 11/22/07 To: 11/22/08
Underwriter: HUB International Institution Affiliation: _____
Amount of Coverage per Occurrence: 1,000,000 Amount of Coverage Aggregate: 3,000,000

Name of Company: _____
Street: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Dates of Coverage (Mo/Yr) From: _____ To: _____
Underwriter: _____ Institution Affiliation: _____
Amount of Coverage per Occurrence: _____ Amount of Coverage Aggregate: _____

Name of Company: _____
Street: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Dates of Coverage (Mo/Yr) From: _____ To: _____
Underwriter: _____ Institution Affiliation: _____
Amount of Coverage per Occurrence: _____ Amount of Coverage Aggregate: _____

Questions regarding licensure and prescriptive privileges:

1.	Have any disciplinary actions** been threatened, initiated or are any pending against you by a state licensure board?	Yes* ☐ No ☑
2.	Has your license to practice in any state ever been denied, limited, suspended or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	Yes* ☐ No ☑
3.	Have your privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily) or have you been called before or warned with regard to these privileges by this state or any jurisdiction or federal agency at any time? Is any such action currently pending?	Yes* ☐ No ☑
4.	Have any formal or written complaints been filed against you with any state professional licensing board?	Yes* ☐ No ☑
5.	Do you hold a narcotic registration for any other state?	Yes* ☐ No ☑

Questions regarding healthcare facility employment and/or privileges:

6.	Has your professional employment ever been suspended, diminished, revoked or terminated at any hospital or healthcare facility or are any proceedings that may result in any such action currently pending?	Yes* ☐ No ☑
7.	Has your medical staff appointment/privileges ever been limited, suspended, diminished, revoked, refused/denied, terminated, restricted, not renewed, relinquished (whether voluntarily or involuntarily) at any hospital or healthcare facility or are proceedings currently pending which may result in any such action?	Yes* ☐ No ☑
8.	Have you ever withdrawn (or voluntarily relinquished) your application for appointment, re-appointment or privileges or resigned from the medical staff because disciplinary action** or loss or restriction of clinical privileges was threatened or before a decision about your appointment and/or privileges was rendered by a hospital's or healthcare organization's governing board?	Yes* ☐ No ☑
9.	Have you ever been the subject of disciplinary action** or proceedings at any healthcare facility?	Yes* ☐ No ☑
10.	Have you ever been investigated for scientific misconduct?	Yes* ☐ No ☑
11.	Have you ever been suspended, sanctioned or restricted from participating in any private, federal or state health program (e.g., Medicare or Medicaid or Blue Cross/Blue Shield)?	Yes* ☐ No ☑
12	Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment or supply house or other business to which patients from this facility might be referred or recommended?	Yes* ☐ No ☑
13.	Have you had an application for membership as a participating provider rejected by any HMO/PPO or other prepaid health care plan or your contract as a participating provider terminated by any HMP/PPO or other prepaid plan?	Yes* ☐ No ☑

Questions regarding liability insurance coverage and claims:

14.	Has your professional liability insurance coverage ever been terminated by action of an insurance company?	Yes* ☐ No ☑
15.	Have you ever been denied professional liability insurance coverage?	Yes* ☐ No ☑
16.	Has your present professional liability insurance carrier excluded any specific procedures from your coverage?	Yes* ☐ No ☑
17	Have there been any suits or claims against you alleging malpractice, negligence, failure to diagnose, etc. which have been pending, opened, or closed during the past ten (10) years?	Yes* ☑ No ☐

Please Note: Liability claims, suits or settlements should include: names, addresses, ages of claimants or plaintiffs; nature and substance of claim; date and place at which claim arose; amounts paid, if any; date and manner of disposition, judgment, settlement or otherwise; date and reason for final disposition; if no judgment or settlement, patient's condition at point of your involvement; patient's condition at end of treatment; and the nature and extent of your involvement with the patient.

Miscellaneous Questions:

18.	Are you unable to perform the essential functions of the position for which you have applied or of the privileges you have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients or staff?	Yes* ☐ No ☑
19.	*Are you currently engaged in the illegal use of drugs?*	Yes* ☐ No ☑
20.	Have you engaged in the illegal use of drugs within the past ten (10) years?	Yes* ☐ No ☑
21.	Have you ever been convicted in a criminal action? (Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace or any conviction of a misdemeanor more than 5 years prior to this application if there has been no criminal conviction of any offense within 5 years of this application.)	Yes* ☐ No ☑
22.	Has your membership in any local, state or national medical society ever been suspended or terminated?	Yes* ☐ No ☑
23.	Have you ever been the subject of an inquiry or disciplinary action** by any governmental or other regulatory agency? Is any such action pending? (Include all documentation relating to all inquiries whether action taken, dismissed or pending. Copy of complaint(s), response(s) to complaint(s) and any/all BORM/APPROPRIATE BOARD letters.)	Yes* ☐ No ☑
24.	Have you failed to complete any CME requirements in the state in which you've been practicing?	Yes* ☐ No ☑

*** Please use Page 13 if you answered "Yes" to any of these questions.** **** Please see Page 14 for definition of "Disciplinary Action"**

Section II – Additional Information

If you have answered "yes" to any of the questions on the Application, please supply the information requested below. Use a separate copy of this form for **each** question and indicate the number of the question to which you are responding.

Question #_ __

PLEASE PRINT OR TYPE RESPONSES

Provider's Name: Marcus Gordon

Medical License Number: 82013

Date of Action/Occurrence: 11/16/92

Date Claim/Complaint/Criminal Case was filed:

Facility Where Incident Occurred: Beth Israel Hospital New York, NY

Status of Claim/Complaint/Criminal Care (open, closed including date closed, etc): Closed 8/2006

Duration of Occurrence:

Professional Liability Carrier Involved:

Amount of Settlement: 35,000.00

Method of Resolution:

- ☐ Dismissed
- ☐ Settled with Prejudice
- ☐ Judgment for Defendant(s)
- ☐ Judgment for Plaintiff(s)
- ☒ Settled without Prejudice
- ☐ Mediation or Arbitration
- ☐ Letter of advice, consent agreement, letter of concern, warning letter, PHS agreement, other (please include a copy)

Date of Settlement/Action Taken: 8/2006

Were you the primary defendant or co-defendant? YES ☒ NO ☐

Detailed Description:

See Attached Page

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
Definition of "Disciplinary Action" (243 CMR 3.02)

(1) An action of any entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, state or local).

(2) An action that is:
- (a) formal or informal, or
- (b) oral or written (except an oral reprimand or admonition is not a "disciplinary action.")

(3) Any of the following actions on their substantial equivalents, whether voluntary or involuntary:

- (a) Revocation of a right or privilege
- (b) Suspension of a right or privilege
- (c) Censure
- (d) Written reprimand or admonition
- (e) Restriction of a right or privilege
- (f) Non-renewal of a right or privilege
- (g) Fine
- (h) Required performance of public service
- (i) A course of education, training, counseling, or monitoring, only is such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee's competence to practice medicine
- (j) Denial of a right or privilege
- (k) Resignation
- (l) Leave of absence
- (m) Withdrawal of an application
- (n) Termination or non-renewal of a contract with a license

(4) Divisions (e), (f) and (j) through (n) above are "disciplinary actions" only if they relate, directly or indirectly, to:

- (a) the licensee's competence to practice medicine, or
- (b) a complaint or allegation regarding any violation of law or regulation (including, but not limited to, the regulations of the Board) or bylaws of a health care facility, medical staff, group practice, or professional medical association, whether or not the complaint or allegation specifically cites violation of a specific law, regulation or by-law.

(5) If based only upon a failure to complete medical records in a timely fashion and/or failure to perform minor administrative functions, the action adversely affecting the licensee is not a "disciplinary action" for the purposes of mandatory reporting to the Board, provided that the adverse action does not relate directly or indirectly to:

- (a) the licensee's competence to practice medicine, or a complaint or allegation regarding any violation of law or a Board regulation, whether or not the complaint or allegation specifically cites violation of a specific law or regulation.

Section IV – Payor Enrollment Information

Practice Information and Demographics

Do you wish to be listed as ☐ Primary Care Physician ☒ Specialist ☐ Both

If you are in Internal Medicine, Family Practice, or Pediatrics, but do not maintain a panel of patients, indicate the services you are providing:

☐ Hospitalist ☐ Covering ☐ Moonlighting ☐ Urgent Care ☐ Locum Tenens: From: _____

To: _____

Do you practice exclusively within an inpatient setting? Yes ☐ No ☒

Do you practice in a private office and submit claims for those services under a separate TID #? Yes ☒ No ☐

If you are a specialist in emergency medicine, radiology, anesthesiology or pathology, do you: (a) provide services exclusi hospital setting and only incident to hospital services; and (b) provide services as a result of patients being directed to the l (c) willing to be not separately identified as available to Members in any Health Plan literature, such as Health Plan direct Yes ☐ No ☐

Are you currently accepting new patients into your practice? Yes ☒ No ☐

Please list all Insurers for which you are currently a provider and your Provider #, if any

Insurer:	Provider #, if any
Blue Cross & Blue Shield of Massachusetts (Indemnity)	
Blue Cross & Blue Shield of Massachusetts (HMO)	J17091
Tufts Health Plan	082013
Harvard Pilgrim Healthcare	130942
Neighborhood Health Plan	0003699
Fallon Community Health Plan	—
Health New England	—
Network Health	—
Medicare	A21704
Medicaid	3155064
Other: Cigna	B208412701
Other: Aetna	42329 43
Aetna HMO	2095063
United MPIN	928327

Professional Practice

☐ Solo		Facility Name:
☐ Partnership	Name of Partner(s):	Facility Name:
☐ Single Specialty Group	Name of Group/Specialty:	Facility Name:
☐ Multi Specialty Group	Name of Group/Specialty:	Facility Name:
☐ Other	Specify:	Facility Name:

Please list conditions that you treat. Please provide up to five particular clinical interests.

family planning, dysfunctional uterine bleeding fibroids	

Under what specialty(s) do you want to be listed in the Insurer's Provider Directory(s)? Gyn

Which age groups do you treat? ☒ All ages ☐ 0-11 yrs ☐ 12-18 yrs ☐ 19-25 ☐ 26-65 yrs ☐ 65+ yrs

List any restrictions on your practice: _____

Length of time it takes for a new patient visit: 1/2 hr. ✓ 1 hr. ____ 1 1/2 hrs. ____ 2 hrs. ____ 2 ½+ hrs. ____

What is the average waiting time for a patient to schedule an appointment:

Type of Visit	Waiting Time
Initial visit to establish a relationship with a physician	4 weeks
Preventative health care visit (routine physical)	2-3 weeks
Urgent visit	1-2 days

What are the average number of visits scheduled per hour? 4

Do you perform laboratory tests in your office? Yes ☑ No ☐

If yes, are you CLIA (Clinical Laboratory Improvement Amendment) certified? Yes ☒ No ☐

Will you be billing for diagnostic interpretations (i.e. interpretation of x-rays)? Yes ☒ No ☐

Please check which of the following diagnostic modalities/facilities are present in your office and list any additional procedures and any special diagnostic testing (e.g., surgical procedures, etc.) you perform in your office, including any special equipment used.

☐ X-ray ☒ Diagnostic Ultrasound ☐ Endoscopy ☐ Routine EKG

☐ Other Cardiac Testing, including _____ ☐ Other _____

Accept Walk-ins? Yes ☐ No ☒

Name of Practice Appointment Secretary: _____

Name of Practice/Office Manager and Email address: Stephanie Lowitt

Which Credit Cards Do You Accept? Mastercard ☒ Visa ☒ AMEX ☒ Other(s) Discover

Do you request payment at the time of Service? Yes ☒ No ☐

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.)

Call or Letter from other physician

What should a patient bring to the appointment? Photo ID, Insurance cards, prior medical history info (unless sent by physician)

What questions should we ask a patient, to help determine the appropriateness of the referral?

Other comments: _____

Billing Information:

Practice Locations (from page 2 of this application)

Name of Primary Practice: North Shore Womens Ctr.	Name of Secondary Practice: Merrimack Valley Womens Health Svcs.
Phone Number: (781) 595 4800	Phone Number: (978) 688-7222

Practice Type: ☐ Solo ☒ Group ☐ Clinic ☐ Other	Practice Type: ☐ Solo ☒ Group ☐ Clinic ☐ Other
Group/Corporate Name as it appears on your W-9:	Group/Corporate Name as it appears on your W-9:
North Shore Womens Center PC	merrimack valley womens Health services, LLC
Language fluency in the office: Spanish	Language fluency in the office: Spanish
Resources for translation:	Resources for translation:
Does the office have handicapped access? Yes ☐ No ☒	Does the office have handicapped access? Yes ☒ No ☐

List Name, Specialty and Phone number of physicians covering your practice in your absence. Your practice must provide 24 hour coverage. (Please attach additional sheet, if necessary)

Name	Specialty	Provider Type	Phone Number
Nilda moreno	Gyn	M.D	617 676 8834

Office/Practice Name: North Shore Womens Center
Street Address: 480 Lynnfield St.
Street Address:
City: Lynn State: MA Zip: 01904
If not currently at this site, expected start date:
OFFICE PHONE #: 781 595 4800
OFFICE FAX #: 781 595 3813

Office Type:
☒ Primary Address — Mailing Address
☐ Administrative Address — YES ☒
☐ Clinical Practice Office — NO ☐
☐ Research Office

Payment information: Make checks payable to: North Shore Womens Center
Payment Address (please provide complete mailing address): PO Box 8434110 Boston MA 02284
Billing entity phone #: IRS Tax ID#:
Applies to: ☒ Primary Practice ☐ Secondary Practice

Office/Practice Name: merrimack Valley Womens Health Services
Street Address: 9 Branch St.
Street Address:
City: methuen State: MA Zip: 01844
If not currently at this site, expected start date:

Office Type:
☐ Primary Address — Mailing Address
☐ Administrative Address — YES

Billing Information:

Practice Locations (from page 2 of this application)

Name of 3rd Practice: Four Women Physician Group	Name of Secondary Practice:
Phone Number: (508) 222 - 7555	Phone Number: ( )

Practice Type: ☐ Solo ☒ Group ☐ Clinic ☐ Other	Practice Type: ☐ Solo ☐ Group ☐ Clinic ☐ Other
Group/Corporate Name as it appears on your W-9: Four Women Physician Group	Group/Corporate Name as it appears on your W-9:
Language fluency in the office: Spanish	Language fluency in the office:
Resources for translation:	Resources for translation:
Does the office have handicapped access? Yes ☒ No ☐	Does the office have handicapped access? Yes ☐ No ☐

List Name, Specialty and Phone number of physicians covering your practice in your absence. Your practice must provide 24 hour coverage. (Please attach additional sheet, if necessary)

Name	Specialty	Provider Type	Phone Number
Milda Moreno	Gyn	MD	617 676 8834

Office/Practice Name: Four Women Physician Group.
Street Address: 150 Emory St.
Street Address:
City: Attleboro State: MA Zip: 02703
If not currently at this site, expected start date:
OFFICE PHONE #: 508 222 7555
OFFICE FAX #: 508 226 2218

Office Type:
☐ Primary Address
☐ Administrative Address
☒ Clinical Practice Office
☐ Research Office

Mailing Address: YES ☐ NO ☒

Payment information: Make checks payable to: Four Women Physician Group
Payment Address (please provide complete mailing address): 150 Emory St. Attleboro MA 02703
Billing entity phone #: 508 IRS Tax ID#:
Applies to: ☒ 3rd Practice ☐ Secondary Practice

Office/Practice Name:
Street Address:
Street Address:
City: State: Zip:
If not currently at this site, expected start date:

Office Type:
☐ Primary Address
☐ Administrative Address

Mailing Address: YES ☐

OFFICE PHONE #: _____
OFFICE FAX #: _____

☐ Clinical Practice Office
☐ Research Office

NO ☐

Payment information: Make checks payable to: _____

Payment Address (please provide complete mailing address): _____

Billing entity phone #: _____ IRS Tax ID#: _____

Applies to: ☐ Primary Practice ☐ Secondary Practice

PLEASE COPY THIS PAGE FOR ADDITIONAL OFFICE LOCATIONS

In the event that the Hospital or Health Plan has any questions about this application, please provide contact information *below*. ***Unanswered or missing information will delay processing of this application and/or may result in the application being returned as incomplete.*** It is essential to have appropriate contact information in order to avoid delays.

Is the mailing address on Page 2 the address to which you want your re-credentialing application sent? YES ☒ NO ☐
(If no, please provide address to which you want your re-credentialing application sent at the bottom of this page.)

Practitioner/Practice Name: Marcus Gordon, MD

Credentialing Contact Name: Stephanie Lowitt

Contact Title: Professional Services Director

Contact Telephone: 508 222 7555 Fax: 508 226 2218

Contact E-Mail: _____

Contact Mailing Address: 150 Emory St.

City: Attleboro State: MA Zip: 02703

Contact hours of availability: 9-5 Mon, Tue, Thurs

Office Hours for: Four Women Health Services
Practitioner/Practice Name

	Start Time	End Time
Monday	9	5
Tuesday	9	5
Wednesday	9	5
Thursday	9	8
Friday	9	5
Saturday	8	12
Sunday	—	—

93-1003

PC

FPC

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

Filing Fee: $125.00
Late Fee: $25.00

0748
165025

Annual Report for Professional and Foreign Professional Corporations

(General Laws Chapter 156A, Section 18 and Chapter 156D, Section 16.22)

(1) Exact name of the corporation: NORTH SHORE WOMEN'S CENTER, P.C.

(2) Jurisdiction of incorporation: MASSACHUSETTS

(3) Street address of the corporation's registered office in the commonwealth:
480 LYNNFIELD ST., LYNN, MA 01904
(number, street, city or town, state, zip code)

(4) Name of the registered agent at the registered office: MARCUS T. GORDON

(5) Street address of the corporation's principal office:
480 LYNNFIELD ST., LYNN, MA 01904
(number, street, city or town, state, zip code)

(6) Provide the names and addresses of the corporation's board of directors, shareholders, and its president, treasurer, secretary, and if different, its chief executive officer and chief financial officer.

	NAME	ADDRESS
President:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Treasurer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Secretary:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Chief Executive Officer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Chief Financial Officer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Directors:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167

Shareholders (with residential address):

(7) Briefly describe the business of the corporation:
MEDICAL OFFICE

(8-9) Capital stock of each class and series:

CLASS OF STOCK	TOTAL AUTHORIZED BY ARTICLES OF ORGANIZATION OR AMENDMENTS Number of Shares	TOTAL ISSUED AND OUTSTANDING Number of Shares
COMMON	1,000	1,000
PREFERRED		

10) Check if the stock of the corporation is publicly traded. ☐

11) Report is filed for fiscal year ending: DECEMBER (month) / 31 (day) / 2006 (year)

is hereby certified, pursuant to G.L. Chapter 156A, Section 18, that the shareholders, and all the partners of a general partnership which is a shareholder of the corporation are duly licensed to render one or more professional services for which the corporation was organized, or are professional corporations authorized to render such professional services, and that a copy of this report is being sent to the appropriate regulatory board.

gned by:

☐ Chairman of the board of directors ☒ President ☐ Other officer ☐ Court appointed fiduciary

this Sixteenth day of March 2007

c156as18c156de1022 01/13/05

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

CERTIFICATE BY REGULATORY BOARD**
(General Laws, Chapter 112 or 221)

In compliance with General Laws, Chapter 156A, Section 7, the Board of Registration in Medicine
(Exact name of board)
hereby certifies that in connection with the incorporation of Merrimack Valley Women's Health Services, LLC
(Exact name of corporation)
a professional corporation formed to render practice of medicine/medical services,
(Type of professional service to be rendered)
the below listed incorporators, officers, directors, and shareholders are duly licensed or admitted to practice the profession listed above.

INCORPORATORS	RESIDENTIAL ADDRESS
Marcus Gordon, M.D.	1101Boylston Street Chestnut Hill, MA 02467

OFFICERS	RESIDENTIAL ADDRESS
N/A	

DIRECTORS	RESIDENTIAL ADDRESS
N/A	

~~SHAREHOLDERS~~ MEMBERS	RESIDENTIAL ADDRESS
Marcus Gordon, M.D.	1101 Boylston Street Chestnut Hill, MA 02467

SIGNED this 17th day of September, 20 04
by _____, *Chairman / *Clerk.

*Delete the inapplicable word.
**Certain regulatory boards may require a fee for the issuance of this certificate.

Internal Revenue Service
DEPARTMENT OF THE TREASURY

The Digital Daily

Federal Tax ID / EIN

This is your provisional Employer Identification Number:

Today's Date is: September 14, 2004 GMT

You will receive a confirmation letter in U.S. mail within fifteen days.
The letter will also contain useful tax information for your business or organization.

If you have input any of the information on your application in error, please wait seven days and contact the EIN Toll Free area at 1-800-829-4933, Monday - Friday, 7:30am - 5:30pm. If you do not want to call, please make corrections on the letter you receive confirming your EIN and return it to the IRS.

If you are going to complete other on-line applications that require your Employer Identification Number(EIN) you can copy it by performing the following steps:

1) Use your mouse to highlight your EIN (blue number on top of page) by moving your pointer on top of the number.
2) Press the Ctrl key at the same time pressing the C key.

Once you copy your EIN you can paste it in the appropriate place by pressing the Ctrl key at the same time pressing the V key.

You may click on the buttons below for different print options or to fill out another Form SS-4.

Review and Print Form SS-4 | Fill Out Another Form SS-4

Click here to return to the Internet Employer Identification Number landing (start) page.

Examiner

Name Approved

PC

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

ARTICLES OF ORGANIZATION
(General Laws, Chapter 156A)

ARTICLE I
The exact name of the corporation is:

North Shore Women's Center, P.C.

ARTICLE II
The purpose of the corporation is to engage in the following business activities:

The practice of medicine, including the performance of all medical and related services, through officers, employees, and agents duly registered and licensed to practice the profession of medicine within the Commonwealth of Massachusetts, together with ancillary and collateral non-professional services rendered by employees not professionally qualified but working under the supervision of professionally qualified officers or employees;

To own real and personal property necessary or appropriate for the rendering of medical and related services; to invest in real estate, mortgages, stocks, bonds, or any other type of investment;

To do or cause to be done any and all such acts and things as may be necessary, desirable, appropriate, convenient, or incidental to the accomplishment or performance of any or all of the foregoing purposes;

and

To engage in any lawful act or activity for which professional corporations may be organized under Massachusetts Professional Corporation Laws.

C
P
M
R.A.

SS054035

8

P.C.

Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

ARTICLE III

State the total number of shares and par value, if any, of each class of stock which the corporation is authorized to issue:

WITHOUT PAR VALUE		WITH PAR VALUE		
TYPE	NUMBER OF SHARES	TYPE	NUMBER OF SHARES	PAR VALUE
Common:		Common:	200,000	$0.01
Preferred:		Preferred:		

ARTICLE IV

If more than one class of stock is authorized, state a distinguishing designation for each class. Prior to the issuance of any shares of a class, if shares of another class are outstanding, the corporation must provide a description of the preferences, voting powers, qualifications, and special or relative rights or privileges of that class and of each other class of which shares are outstanding and of each series then established within any class.

NONE

ARTICLE V

The restrictions, if any, imposed by the Articles of Organization upon the transfer of shares of stock of any class are:

Stock of the corporation shall be issued in accordance with Section 1244 of the Internal Revenue Code, or its successor sections.

See Continuation Sheet 5A attached hereto and incorporated by reference.

ARTICLE VI

**Other lawful provisions, if any, for the conduct and regulation of the business and affairs of the corporation, for its voluntary dissolution, or for limiting, defining, or regulating the powers of the corporation, or of its directors or stockholders, or of any class of stockholders:

The Directors may amend or repeal the by-laws in whole or in part except with respect to any provision(s) thereof which by law or under the by-laws requires action by shareholders.

See Continuation Sheet 6A attached hereto and incorporated by reference.

***If there are no provisions state "None".*

Note: The preceding six (6) articles are considered to be permanent and may only be changed by filing appropriate Articles of Amendment.

CONTINUATION SHEET 5A

Any stockholder, including the heirs, assigns, executors or administrators of a deceased stockholder, desiring to sell or transfer such stock owned by him or them, shall first offer it to the professional corporation through the Board of Directors, in the manner following:

He shall notify the directors of his desire to sell or transfer by notice in writing, which notice shall contain the price at which he is willing to sell or transfer and the name of one arbitrator. The directors shall, within thirty days thereafter, either accept the offer, or by notice to him in writing, name a second arbitrator, and these two shall name a third. It shall then be the duty of the arbitrators to ascertain the value of the stock, and if any arbitrator shall neglect or refuse to appear at any meeting appointed by the arbitrators, a majority may act in the absence of such arbitrator.

After the acceptance of the offer, or the report of the arbitrators as to the value of the stock, the directors shall have thirty days within which to purchase the same at such valuation, but if at the expiration of thirty days, the professional corporation shall not have exercised the right so to purchase, the owner of the stock shall be at liberty to dispose of the same in any manner he may see fit.

No shares of stock shall be sold or transferred on the books of the professional corporation until these provisions have been complied with, but the Board of Directors may in any particular instance waive the requirement.

A shareholder may transfer shares and rights or options to purchase shares of the professional corporation only to qualified persons as defined in Massachusetts General Laws Chapter 156A. Subject to Sections 12 and 13 of said Chapter 156A, nothing contained herein shall prohibit the pledge of shares of the professional corporation to a disqualified person or the transfer of such shares by operation of law or court decree to a disqualified person.

Every certificate issued representing shares of this professional corporation shall state thereon in bold print that the shares represented thereby are subject to restrictions on transfer imposed by Massachusetts General Laws Chapter 156A and any further restrictions on transfer imposed by the Board of Registration in Medicine from time to time pursuant to said Chapter.

CONTINUATION SHEET 6A

6. Other lawful provisions for the conduct and regulation of the business and affairs of the professional corporation, for its voluntary dissolution, or for limiting, defining or regulating the powers of the professional corporation, or of its directors or stockholders, or any class of stockholders:

(a) The directors may make, amend or repeal the By-Laws in whole or in part, except with respect to any provision thereof which by law or in accordance with the terms of the By-Laws require action by the stockholders.

(b) Meetings of the stockholders may be held anywhere in the United States.

(c) The professional corporation may be a partner in any business enterprise it would have power to conduct by itself.

(d) The directors shall have the power to fix from time to time their compensation. No person shall be disqualified from holding any office by reason of any interest. In the absence of fraud, any director, officer or stockholder of this professional corporation, or any concern which is a stockholder of this professional corporation individually, or any individual having any interest in any concern which is a stockholder of this professional corporation, or any concern in which any such directors, officers, stockholders or individuals have any interest, may be a party to, or may be pecuniarily or otherwise interested in, any contract, transaction or other act of this professional corporation, and

(1) such contract, transaction or act shall not be in any way invalidated or otherwise affected by that fact;

(2) no such director, officer, stockholder or individual shall be liable to account to this professional corporation for any profit or benefit realized through any such contract, transaction or act; and

(3) any such director of this professional corporation may be counted in determining the existence of a quorum at any meeting of the directors or of any committee thereof which shall authorize any such contract, transaction or act, and may vote to authorize the same.

The term "interest" shall include personal interest and interest as a director, officer, stockholder, shareholder, trustee, member or beneficiary of any concern.

The term "concern" shall mean any corporation, association, trust, partnership, firm, person or other entity other than this professional corporation.

(e) No Director shall be personally liable to the professional corporation or any stockholder for monetary damages for breach of fiduciary duty as a director, except for any matter in respect of which such director shall be liable under Sections 61 and 62 of Chapter 156B of the Massachusetts General Laws or any amendment thereto or successor provision thereto or shall be liable by reason that, in addition to any and all other requirements for such liability, he (i) shall have breached his duty of loyalty to the professional corporation or its stockholders, (ii) shall not have acted in good faith or, in failing to act, shall not have acted in good faith, (iii) shall have acted in a manner involving intentional misconduct or knowing violation of law, or (iv) shall have derived an improper personal benefit. Neither the amendment nor repeal of this paragraph shall eliminate or reduce the effect of this paragraph in respect of any matter occurring, or any cause of action, suit or claim that, but for this paragraph would accrue or arise, prior to such amendment, repeal or adoption of an inconsistent provision.

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

CERTIFICATE BY REGULATORY BOARD
(General Laws, Chapter 112 or 221)

In compliance with General Laws, Chapter 156A, Section 7, the Board of Registration in Medicine
(Exact name of board)

hereby certifies that in connection with the incorporation of North Shore Women's Center, P.C.
(Exact name of corporation)

a professional corporation formed to render medical services,
(Type of professional service to be rendered)

the below listed incorporators, officers, directors, and shareholders are duly licensed or admitted to practice the profession listed above.

INCORPORATORS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

OFFICERS	RESIDENTIAL ADDRESS
President: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167
Treasurer: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167
Clerk: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

DIRECTORS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

SHAREHOLDERS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

SIGNED this 19th day of February, 19 98.

by Marcus T. Gordon MD, *Chairman / *Clerk.

*Delete the inapplicable word.

ARTICLE VII

The effective date of organization of the corporation shall be the date approved and filed by the Secretary of the Commonwealth. If a *later* effective date is desired, specify such date which shall not be more than thirty days after the date of filing.

ARTICLE VIII

The information contained in Article VIII is not a permanent part of the Articles of Organization.

a. The street address (post office boxes are not acceptable) of the principal office of the corporation *in Massachusetts* is:

583 Chestnut Street, Lynn, MA 01904

b. The name, residential and post office address of each director, officer and shareholder of the corporation is as follows:

	NAME	RESIDENTIAL ADDRESS	POST OFFICE ADDRESS
President:	Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167	
Treasurer:	Marcus T. Gordon, M.D.	-- same --	
Clerk:	Marcus T. Gordon, M.D.	-- same --	
Directors:	Marcus T. Gordon, M.D.	-- same --	
Shareholders:	Marcus T. Gordon, M.D.	-- same --	

c. The fiscal year of the corporation shall end on the last day of the month of: December

d. The name and business address of the resident agent, if any, of the corporation is:

Colin A. Coleman, Esq., P.O. Box 915, 20 Pickering Street, Needham, MA 02192

Please insert the required certificate(s) from the appropriate regulatory board(s).

ARTICLE IX

By-laws of the corporation have been duly adopted and the president, treasurer, clerk and directors whose names are set forth above, have been duly elected.

IN WITNESS WHEREOF AND UNDER THE PAINS AND PENALTIES OF PERJURY, I/we, whose signature(s) appear below as incorporator(s) and whose name(s) and business or residential address(es) *are clearly typed or printed* beneath each signature do hereby associate with the intention of forming this corporation under the provisions of General Laws, Chapter 156A and do hereby sign these Articles of Organization as incorporator(s) this 11th day of February, 19 98.

Marcus T. Gordon, M.D., Incorporator

583 Chestnut Street, Lynn, MA 01904

Note: If an existing corporation is acting as incorporator, type in the exact name of the corporation, the state or jurisdiction where it was incorporated, the name of the person signing on behalf of said corporation and the title he/she holds or other authority by which such action is taken.

607186

THE COMMONWEALTH OF MASSACHUSETTS

SECRETARY OF THE COMMONWEALTH

98 FEB 23 AM 11:00

CORPORATION DIVISION

ARTICLES OF ORGANIZATION

(General Laws, Chapter 156A)

I hereby certify that, upon examination of these Articles of Organization, duly submitted to me, it appears that the provisions of the General Laws relative to the organization of corporations have been complied with, and I hereby approve said articles; and the filing fee in the amount of $ 200.00 having been paid, said articles are deemed to have been filed with me this 23rd day of FEBRUARY 19 98

Effective date: _____

William Francis Galvin

WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

FILING FEE: One tenth of one percent of the total authorized capital stock, but not less than **$200.00.** For the purpose of filing, shares of stock with a par value less than $1.00, or no par stock, shall be deemed to have a par value of $1.00 per share.

TO BE FILLED IN BY CORPORATION
Photocopy of document to be sent to:

Alice B. Taylor, Esq.
Colin A. Coleman & Associates
20 Pickering Street; P.O. Box 915
Needham, MA 02192

Telephone: 781-444-2333

043411880 BT 00 000000 0401
199815 R09597

Department of the Treasury
Internal Revenue Service
ANDOVER, MA 05501

Date of this notice: APR. 27, 1998
Taxpayer Identifying Number
Form: Tax Period:

For assistance you may call us at:

617-536-1040
1-800-829-1040

Or you may write to us at the address shown at the left. If you write, be sure to attach the bottom part of this notice.

NORTH SHORE WOMENS CENTER P C
583 CHESTNUT ST
LYNN MA 01904-2600837

NOTICE OF ACCEPTANCE AS AN S-CORPORATION

YOUR ELECTION TO BE TREATED AS AN S-CORPORATION WITH AN ACCOUNTING PERIOD OF DECEMBER IS ACCEPTED. THE ELECTION IS EFFECTIVE BEGINNING FEB. 23, 1998, SUBJECT TO VERIFICATION IF WE EXAMINE YOUR RETURN.

IF YOUR EFFECTIVE DATE IS NOT AS REQUESTED, IT WILL HAVE BEEN CHANGED FOR ONE OF TWO REASONS. EITHER YOUR ELECTION WAS MADE AFTER THE 15TH DAY OF THE THIRD MONTH OF THE TAX YEAR TO WHICH IT APPLIES, BUT BEFORE THE END OF THAT TAX YEAR, OR THE ELECTION WHEN SUBMITTED WAS INCOMPLETE, AND REQUESTED INFORMATION WAS RECEIVED AFTER THE FILING PERIOD. IN EITHER CASE, YOUR ELECTION IS INVALID FOR THE TAX YEAR REQUESTED AND HAS THEREFORE, BEEN TREATED AS THOUGH IT WERE MADE FOR THE NEXT TAX YEAR.

PLEASE KEEP THIS NOTICE IN YOUR PERMANENT RECORDS AS VERIFICATION OF YOUR ACCEPTANCE AS AN S-CORPORATION.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR THE ACTIONS WE HAVE TAKEN, PLEASE WRITE TO US AT THE ADDRESS SHOWN ABOVE. IF YOU PREFER, YOU MAY CALL US AT THE IRS TELEPHONE NUMBER LISTED IN YOUR LOCAL DIRECTORY. AN EMPLOYEE THERE MAY BE ABLE TO HELP YOU; HOWEVER, THE OFFICE AT THE ADDRESS SHOWN ON THIS NOTICE IS MOST FAMILIAR WITH YOUR CASE.

IF YOU WRITE TO US, PLEASE PROVIDE YOUR TELEPHONE NUMBER AND THE MOST CONVENIENT TIME FOR US TO CALL SO WE CAN CONTACT YOU TO RESOLVE YOUR INQUIRY. PLEASE RETURN THE BOTTOM PART OF THIS NOTICE TO HELP US IDENTIFY YOUR CASE.

THANK YOU FOR YOUR COOPERATION.

To make sure that IRS employees give courteous responses and correct information to taxpayers, a second IRS employee sometimes listens in on telephone calls.

Overlay 5 Form 8489 (Rev.8-9

Keep this part for your records

Return this part to us with your check or inquiry

Your telephone number	Best time to call
( ) -	

261

INTERNAL REVENUE SERVICE
ANDOVER, MA 05501

NORTH SHORE WOMENS CENTER P C
583 CHESTNUT ST
LYNN MA 01904-2600837

165025

Section III -- Applicant's Authorization and Release

I hereby apply for:

1. Medical/professional staff appointment and clinical privileges as requested herein at each hospital to which I submit this application (Hospital); and
2. Participation as a network or health plan provider with each provider network or health plan to which I submit this application (Health Plan).

I am willing to make myself available for interviews in regard to this application. I also agree to provide each Hospital and Health Plan with updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital(s), Health Plan(s) or their respective authorized representatives. I understand that failure to provide all information requested will prevent evaluation of and/or action on my application.

I hereby attest that the information in or attached to this application is true and complete and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges requested. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may constitute sufficient cause for rejection of this application resulting in denial of Hospital appointment and clinical privileges or Health Plan network participation. In the event that Hospital appointment or privileges, or Health Plan network participation, has/have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination of such appointment or privileges, or network participation.

I understand that with the exception of information determined by the Hospital or Health Plan to be peer review protected, I have the right to request in writing and subsequently review any information obtained by the Hospital or Health Plan to support its evaluation of my application and to correct any erroneous information.

I agree that if I am granted Hospital clinical privileges or Health Plan network participation, I will maintain during the term of my appointment or participation malpractice insurance coverage in an amount equal to or greater than the minimum required by the Hospital or Health Plan respectively and with a carrier acceptable to the Hospital or Health Plan respectively.

I hereby authorize the Hospital and the Health Plan to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records which shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting, as well as to my moral and ethical qualifications.

I hereby authorize any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualification to provide and/or release information (both written and oral) to representatives of the Hospital and its medical/professional staff and to the Health Plan bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications. Such information includes but is not limited to information regarding any and all malpractice actions, pending or final disciplinary actions and alterations in privileges, and any information with respect to whether I am able to perform the essential functions of the position for which I have applied or the privileges I have requested with or without a reasonable accommodation, according to accepted standards of professional practice and without posing a direct threat to patients or staff (including without limitation information regarding any impairment due to the use of drugs or alcohol).

I authorize and request my medical malpractice liability insurance carrier to release information to the Hospital and Health Plan regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

If requested, I agree to undergo a mental or physical examination, prior to or during the term of my appointment to determine whether I am able to perform the essential functions of the position for which I have applied or for the privileges which I have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a threat to patients or staff.

I agree to notify the Hospital and Health Plan as soon as I become aware that any health care organization, Hospital or any licensing, certifying or regulatory authority has initiated or taken disciplinary action of any kind against me, or has initiated an investigation as a result of a complaint or allegation against me.

I hereby release from liability any and all individuals and organizations that, in good faith and without malice, provide information to the Hospital and Health Plan or to their respective medical/professional staff for the purpose of evaluating this application. I also hereby release from liability the Hospital and Health Plan, their respective medical/professional staffs and their respective agents and representatives for their

Applicant's Authorization and Release (cont'd)

acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials and qualifications.

I agree that a photocopy of this Authorization and Release will be as valid as the original, and that this Authorization and Release will remain valid as to each Hospital and Health Plan unless revoked by me in writing, or the date on which the Hospital or Health Plan next conducts re-credentialing of my status with the Hospital or Health Plan.

This Section Applies to Applications for Hospital Appointments and Privileges:

I acknowledge that (1) a medical/professional staff appointment and clinical privileges at the Hospital is not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the Hospital(s) and Medical/Professional Staff Bylaws, policies and procedures, and rules and regulations; (3) all recommendations relative to my application are subject to the ultimate action of the Hospital Board, whose decision shall be final; (4) if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board; (5) I have the responsibility to keep this application current by informing the Hospital of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical/professional staff status at any other hospital, or with any other health care organization or professional organization; and (6) reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the Hospital, as evidenced by appropriate treatment and continuous care of patients for whom I have responsibility, and acceptable performance of all duties related thereto as well as the other factors deemed relevant by the Hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to Hospital and Medical/Professional Staff Bylaws, polices and procedures and upon final approval of the Hospital Board.

I have received and had an opportunity to read the Bylaws of the Medical/Professional Staff. I specifically agree to abide by all such bylaws and any policies and procedures that are applicable to appointees to the Medical/Professional Staff.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) abide by standards of clinical practice that may be in effect from time to time; (7) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and (8) as required by my appointment to the Hospital(s), accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Hospital(s) Board and medical/professional staff.

This Section Applies to Applications for Participation in Provider Networks:

I acknowledge that (1) participation in the provider network or networks operated or contracted by the Health Plan is not a right of every licensed professional who makes application for the same; (2) acceptance of this application does not constitute approval or acceptance of participation until such time as a provider contract is executed by me and the Health Plan to which I have applied; (3) my request will be evaluated in accordance with prescribed procedures defined in the Health Plan's policies and procedures; (4) all recommendations relative to my application are subject to the ultimate action of the Health Plan's credentialing committee, or other governing body designated by the Health Plan, whose decision shall be final; (5) I have the responsibility to keep this application current by informing the Health Plan of any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical/professional staff status, including but not limited to a disciplinary action, at any hospital, or with any other health care organization or professional organization; (6) my continued participation in the provider network remains contingent upon my continued demonstration of professional competence, continued compliance with the Health Plan's credentialing criteria, compliance with the Health Plan's policies and procedures for re-credentialing, and compliance with my contract with the Health Plan; and (7) my complete name and title, specialty or specialties, hospital affiliations, practice addresses, telephone number, languages spoken and handicap accessibility at my practice locations may be included in a physician directory prepared for enrollees of each Health Plan with whom I sign contract.

Further, I authorize the Health Plan(s) to provide my credentialing status to my affiliated provider organization's leaders and notwithstanding anything to the contrary contained in any agreement, I authorize the Health Plan(s) to release my name, address, telephone number, tax identification number and other identifying information to individuals and entities for legitimate business purposes related to the administration of Health Plan products and services.

SIGNATURE: _____ DATE SIGNED: 7/26/07

PRINT NAME: Marcus Gordon, MD

165025

The Commonwealth of Massachusetts

REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

NUMBER	ISSUED	TYPE
	07/14/06	CONTROLLED SUBSTANCES PRACTITIONER

SCHEDULES
II,III,IV,V,VI

ISSUED TO

GORDON, MARCUS T MD
480 LYNNFIELD STREET
LYNN, MA 01904

COMMISSIONER OF PUBLIC HEALTH

374653

RECIPIENT'S COPY

RECALL

165025

165025

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
	09-30-2009	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	09-19-2006

GORDON, MARCUS T MD
480 LYNNFIELD STREET
LYNN, MA 01904

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

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	09-30-2009	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	09-19-2006

GORDON, MARCUS T MD
480 LYNNFIELD STREET
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Form DEA-223 (05/04)

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

MassHealth Provider Recredentialing Form for Group Practices

0748165025

For office use only
Date received

This form is for recredentialing group practices, as defined in MassHealth regulations at 130 CMR 450.101. Some fields are prefilled, including your MassHealth provider number. Please answer all questions as they relate to that provider number. Please review and verify the preprinted information on this form, correct any errors or outdated information, and complete other fields as applicable. Return this completed form and the required attachments listed in Section 7 of this form to: MedAdvantage, Attn: MassHealth Recredentialing, 11301 Corporate Blvd., Suite 300, Orlando, FL 32817.

SECTION I. ORGANIZATIONAL INFORMATION

1.1 Provider Information

Provider name: NORTH SHORE WOMENS CTR MassHealth provider no.: 9783237

Tax ID no.: _____

Please check the types of professionals that are organized under this group practice (Check all that apply.):

- ☐ audiologist
- ☐ chiropractor
- ☐ dentist
- ☐ hearing instrument specialist
- ☐ *independent nurse midwife*
- ☐ independent nurse practitioner
- ☐ occupational therapist
- ☐ optician
- ☐ optometrist
- ☐ *physical therapist*
- ☐ physician
- ☐ podiatrist
- ☐ psychologist
- ☐ speech therapist

1.2 Organizational Information

Please identify your legal-entity type (Check one.):

Please identify your legal-entity type:

☐ Corporation (indicate type of corporation below.)

☒ profit (includes limited liability companies and professional corporations) ☐ nonprofit

State where incorporated: MA Date of incorporation: _____

☐ Partnership (indicate type of partnership below.)

- ☐ limited partnership, profit
- ☐ limited partnership, nonprofit
- ☐ limited liability partnership, profit
- ☐ limited liability partnership, nonprofit
- ☐ general partnership, profit
- ☐ general partnership, nonprofit

State where partnership was formed: _____ Date partnership was formed: _____

☐ Trust (indicate type of trust below.)

☐ profit ☐ nonprofit State where trust was established: _____ Date trust was established: _____

☐ Governmental (indicate type of governmental entity below.)

☐ federal ☐ state ☐ county ☐ municipal ☐ other (specify): _____

☐ Other entity (specify): _____

1.3 History of Ownership

Has this practice or organization had other owners in the past 10 years?

☐ yes. Provide the information requested below. ☒ no. Skip to Section 2.

Previous owner's name:	Previous tax ID no.:
Previous MassHealth provider name, if applicable:	MassHealth provider no., if applicable:
Dates of ownership (from/through):	

Attach additional pages if necessary.

SECTION 2. ADDRESS INFORMATION

If you need to change your legal entity, payment, or remittance advice address, please complete the enclosed W-9 form and submit it with this recredentialing form.

2.1 Legal Entity Address

Name of business: North Shore Womens Center, PC

Street address: 480 Lynnfield St.

City: Lynn State: MA Zip: 01904 County:

Contact person: Stephanie Lowitt Office phone no.: 781595 4800

E-mail address: slawittnswc@hotmail.com Office fax no.: 781 595 3843

Please choose the method by which this office prefers to be contacted by MassHealth: ☐ e-mail ☑ phone ☐ fax

2.2 Service Site

Answer the following questions for each service site. A service site is a place where you provide professional services to MassHealth members. Attach additional pages if necessary.

National provider identifier (NPI): Taxonomy code:

Is this location: ☑ the primary location? ☐ an off-site clinic? ☐ a branch office? ☐ a multi-campus site?

Street address: **480 LYNNFIELD STREET**

City: **LYNN** State: **MA** Zip: **01904** County:

Contact person: Stephanie Lowitt Office phone no.: **7815954800**

E-mail address: slowittnswc@hotmail.com Office fax no.: 781 595 3843

Please choose the method by which this office prefers to be contacted by MassHealth: ☐ e-mail ☑ phone ☐ fax

Is this location ADA/Section 508-compliant for patient access? ☐ yes ☑ no

Does this site have TTY/TDD capability? ☐ yes ☑ no

If so, what is the phone number?

What are the hours of operation? Mon-Thurs 9-5, Fri 9-6

Please identify languages other than English that are spoken by the staff at this practice location:

Languages: Spanish

Are laboratory tests performed at this office? ☐ yes. CLIA no.: expiration: ☒ no

Are mammograms performed at this office? ☐ yes. Massachusetts Mammography Certificate no.: ☒ no

2.3 Payment Address

Name of business: North Shore womens Center

Street address or P.O. box: Po Box 843410

City: Boston State: MA Zip: 02284 County:

Contact person: Stephanie Lowitt Office phone no.: 781595 4800

E-mail address: slowitt nswc@hotmail.com Office fax no.: 781595 3843

Please choose the method by which this office prefers to be contacted by MassHealth: ☑ e-mail ☐ phone ☐ fax

Do you currently receive payment by electronic funds transfer (EFT)? ☑ yes ☐ no

MassHealth prefers to pay providers by EFT. EFT saves taxpayer money and ensures secure and timely payments. If you currently receive MassHealth payments by check and wish to receive payment by EFT, please attach a completed EFT-1 to this form.

Please go to the next page. ▶

SECTION 2. ADDRESS INFORMATION (cont.)

2.4 Remittance Advice Address

Name of business: North Shore Womens Center

Street address or P.O. box: PO Box 843410

City: Boston State: MA Zip: 02284 County:

Contact person: Stephanie Lowitt Office phone no.: 781 595 4800

E-mail address: slowittnswc@hotmail.com Office fax no.: 781 595 3843

Please choose the method by which this office prefers to be contacted by MassHealth: ☑ e-mail ☐ phone ☐ fax

2.5 Billing Information Address

Name of business: See Above

Street address or P.O. box:

City: State: Zip: County:

Contact person: Office phone no.:

E-mail address: Office fax no.:

Please choose the method by which this office prefers to be contacted by MassHealth: ☑ e-mail ☐ phone ☐ fax

Do you use a billing agent for claims submission? ☑ yes ☐ no

Do you, or does a billing agent on your behalf, submit claims electronically to MassHealth?

☑ yes. Complete the information below. ☐ no ☐ not yet, but I am interested in learning more about submitting claims electronically.

Software vendor name: Athena Health

Software vendor phone no.: 866 265 7922

Date you, or your billing agent on your behalf, began submitting claims electronically: 3/31/03

2.6 Publications Address

MassHealth will notify you about the issuance of bulletins and transmittal letters according to your preferences. Please indicate your choice and include all contact information requested below.

Preferred method of communication:

☑ e-mail (fastest)

☐ postcard notification of publication on Web site (up to 10 days later than e-mail)

☐ printed copy mailed (up to 10 days later than e-mail)

Name of business: North Shore Womens Center

Contact person: Stephanie Lowitt Office phone no.:

E-mail address: slowittnswc@hotmail.com

Street address or P.O. box: 4180 Lynnfield St.

City: Lynn State: MA Zip: 01904 County:

Please go to the next page. ▶

SECTION 3. PROVIDER INFORMATION

3.1 Current and Previous Medicare Provider Numbers

Do you have, or have you ever had, a Medicare provider number? ☑ yes ☐ no

If yes, list all current and prior Medicare provider numbers for your group practice.

Current Medicare provider no.: M21447

Previous Medicare provider no.: _____

Do you have an agreement with any Medicare carrier(s)? ☐ yes ☑ no

If yes, list carrier(s): _____

3.2 Affiliations

Please list all corporations, foundations, facilities, and groups with which this provider has been affiliated in the past seven years for purposes of providing health-care services. Include research sites, even if they are not funded by MassHealth.

Name of organization	Affiliated from	Through	City	State

If discontinued, reason:

Name of organization	Affiliated from	Through	City	State

If discontinued, reason:

Name of organization	Affiliated from	Through	City	State

If discontinued, reason:

SECTION 4. PROVIDER SERVICES INFORMATION

4.1 Commercial Insurance

Do you participate with any commercial insurance plans? ☑ yes ☐ no

If yes:

Name of plan: Blue Cross Blue Sheild, Tufts, Harvard Pilgrim

Name of plan: _____

4.2 Client Age

How old are the patients who receive services from this provider? (Check one, and fill in the blank if applicable.)

☑ any age ☐ only members younger than age _____ ☐ only members older than age _____

4.3 Accepting New Patients?

Is this group practice accepting new patients? ☑ yes ☐ no

4.4 Primary Care Clinician (PCC) Providers Only

What is your capacity for PCC Plan members? (Please enter the number of PCC Plan members you are willing to accept. If nothing is entered, the default is 1,500.) _____

Do you provide 24-hour coverage? ☐ yes ☐ no

If no, explain: _____

Please go to the next page. ▶

SECTION 4. PROVIDER SERVICES INFORMATION (cont.)

Please provide the names and MassHealth provider numbers of practitioners covering for PCCs when the PCC is unavailable. Attach additional pages if necessary.

Clinician's name: ____ MassHealth provider no.: ____

Clinician's name: ____ MassHealth provider no.: ____

Clinician's name: ____ MassHealth provider no.: ____

4.5 Individual Practitioners

Please identify all practitioners who are part of the group practice. Include the practitioner's full name, MassHealth provider number, NPI, taxonomy code, specialties, street address and city of primary service site, and whether or not the practitioner is enrolled as a Primary Care Clinician (PCC) in the MassHealth PCC Plan. Attach additional pages if necessary. If you prefer, you may substitute a facsimile containing the requested information.

Full name Marcus Gordon MD	MassHealth provider no. 3155064	NPI 1013925569	Check here if PCC: ☐
Taxonomy code	Specialties Gyn		
Primary service site – street address and city 480 Lynnfield St. Lynn, MA 01904			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Full name	MassHealth provider no.	NPI	Check here if PCC: ☐
Taxonomy code	Specialties		
Primary service site – street address and city			

Please go to the next page. ▶

SECTION 5. OWNERSHIP AND CONTROL INFORMATION

5.1 Definitions

Section 5 requests information about ownership and control interest of the provider. This section contains a number of terms that are specifically defined in 42 CFR 455.100. For your convenience, the definitions are provided below.

Agent – any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity – a Medicaid provider (other than an individual practitioner or group of practitioners).

Indirect ownership interest – an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee – *a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.*

Other disclosing entity – any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII (Medicare), or XX of the federal Social Security Act. This includes:

(a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) any Medicare intermediary or carrier; and

(c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Social Security Act.

Ownership interest – the possession of equity in the capital, the stock, or the profits of the disclosing entity. "Person with an ownership or control interest" means a person or corporation that–

(a) has an ownership interest totaling five percent or more in a disclosing entity;

(b) has an indirect ownership interest equal to five percent or more in a disclosing entity;

(c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity;

(d) owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity;

(e) is an officer or director of a disclosing entity that is organized as a corporation; or

(f) is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction – any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

Subcontractor –

(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier – an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier – a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Please go to the next page. ▶

SECTION 5. OWNERSHIP AND CONTROL INFORMATION (cont.)

5.2 Officers, Directors, Partners, and Trustees

Are you organized as a corporation, partnership, or trust?

☑ yes. Provide the information requested below. ☐ no. Skip to Section 5.3.

Space is provided for one individual. Attach additional sheets for each officer, director, partner, and trustee.

Last name: Gordon First name: Marcus Middle initial: T

Street Address: 1101 Boylston St.

City: Chestnut Hill State: MA Zip: 02467

Tax ID no.: _____ ☒ social security no. ☐ employer identification no.

This individual is: ☐ an officer ☒ a director ☐ a partner ☐ a trustee

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider? ☐ yes ☒ no

If yes, indicate the relationship: ☐ spouse ☐ sibling ☐ parent ☐ child ☐ other. Specify: _____

Does the officer have an ownership or control interest in another MassHealth provider?

☒ yes ☐ no ☐ The provider has made a written request for this information, but has not received a response from the officer.

Has the officer been convicted of a criminal offense related to the officer's involvement in any program established under Medicaid, Medicare, or the Social Security Act? ☐ yes ☒ no

If yes, attach a sheet describing the nature of the offense. If the provider has ever been sanctioned by MassHealth, a professional review organization, an HMO, a credentialing program, or a board of registration, attach a description including the date and current status of the sanction action.

5.3 Ownership and Control Interest

Provide the information requested below for all individuals or organizations that have ownership or control interest of five percent or more in the provider. Attach additional sheets for each individual and organization.

Party's name: Marcus Gordon, MD

The above party is: ☒ an individual ☐ an organization

Street address: 1101 Boylston St

City: Chestnut Hill State: MA Zip: 02467

Tax ID no.: _____ ☑ social security no. ☐ employer identification no.

The above party has 100 % ownership or control interest in the provider.

The type of interest the party has in the provider is: ☐ capital ☐ stock ☒ profit ☐ secured credit

☐ other (describe): _____

Is there a family relationship between the interested party and persons holding an ownership or control interest in the provider? ☐ yes ☒ no

If yes, indicate the relationship: ☐ spouse ☐ sibling ☐ parent ☐ child ☐ other. Specify: _____

Does the interested party have an ownership or control interest in another MassHealth provider?

☒ yes ☐ no ☐ The provider has made a written request for this information, but has not received a response.

Has the interested party been convicted of a criminal offense related to the party's involvement in any program established under Medicaid, Medicare, or the Social Security Act? ☐ yes ☒ no

If yes, attach a sheet describing the nature of the offense. If the provider has ever been sanctioned by MassHealth, a professional review organization, an HMO, a credentialing program, or a board of registration, attach a description including the date and current status of the sanction action.

Please go to the next page. ▶

SECTION 5. OWNERSHIP AND CONTROL INFORMATION (cont.)

5.4 Subcontractor Information

Do you use any subcontractors as defined in Section 5.1?

☐ yes. Provide the information requested below. ☒ no. Skip to Section 5.5.

Space is provided for one subcontractor. Attach additional sheets for additional subcontractors.

Name of subcontractor: _____

The above subcontractor is: ☐ an individual ☐ an organization

Street address: _____

City: _____ State: _____ Zip: _____

Tax ID no.: _____ ☐ social security no. ☐ employer identification no.

The provider has _____ % ownership or control interest in the subcontractor.

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider? ☐ yes ☐ no

If yes, indicate the relationship: ☐ spouse ☐ sibling ☐ parent ☐ child ☐ other. Specify: _____

Does the subcontractor have an ownership or control interest in another MassHealth provider?

☐ yes ☐ no ☐ The provider has made a written request for this information, but has not received a response.

Has the subcontractor been convicted of a criminal offense related to the subcontractor's involvement in any program established under Medicaid, Medicare, or the Social Security Act? ☐ yes ☐ no

If yes, attach a sheet describing the nature of the offense. If the provider has ever been sanctioned by MassHealth, a professional review organization, an HMO, a credentialing program, or a board of registration, attach a description including the date and current status of the sanction action.

Do other parties have an ownership or control interest of five percent or more in the subcontractor?

☐ yes. Provide the information requested below. ☐ no. Skip to Section 5.5.

Space is provided for one subcontractor. Attach additional sheets for additional subcontractors.

Name of party: _____

The above party is: ☐ an individual ☐ an organization

Street address: _____

City: _____ State: _____ Zip: _____

Tax identification no.: _____ ☐ social security no. ☐ employer identification number

The provider has _____ % ownership or control interest in the subcontractor.

Is there a family relationship between the officer and persons holding an ownership or control interest in the provider? ☐ yes ☐ no

If yes, indicate the relationship: ☐ spouse ☐ sibling ☐ parent ☐ child ☐ other. Specify: _____

Does the subcontractor have an ownership or control interest in another MassHealth provider?

☐ yes ☐ no ☐ The provider has made a written request for this information, but has not received a response.

Has the interested party been convicted of a criminal offense related to the party's involvement in any program established under Medicaid, Medicare, or the Social Security Act? ☐ yes ☐ no

If yes, attach a sheet describing the nature of the offense. If the provider has ever been sanctioned by MassHealth, a professional review organization, an HMO, a credentialing program, or a board of registration, attach a description including the date and current status of the sanction action.

Please go to the next page. ▶

SECTION 5. OWNERSHIP AND CONTROL INFORMATION (cont.)

5.5 Property Owner

Does someone other than the provider own the real property occupied and used by the provider at the service location address?

☒ yes. Provide the information requested below for each individual or organization with an interest of five percent or more in the real property. Attach additional sheets, if necessary.

☐ no. Skip to Section 5.6.

If the property is held by a realty trust, submit a copy of the trust agreement, including the schedules of beneficial owners.

Property owner's name: North Shore Medical Center

The above party is: ☐ an individual ☒ an organization

Street address: 81 Highland Ave

City: Salem State: MA Zip: 01970

Tax ID no.: _____ ☐ social security no. ☐ employer identification no.

The provider has Ø % ownership or control interest in the subcontractor.

The above party has 100 % ownership or control interest in the real property.

5.6 Other Disclosing Entities

Does any individual or organization listed in Sections 5.2 through 5.5 have an ownership or control interest of five percent or more in another Medicaid provider?

☒ yes. Provide the information requested below for each individual or organization with an interest of five percent or more in another Medicaid provider. Attach additional sheets, if necessary.

☐ no. Skip to Section 6.

Name of the individual with ownership or control interest: Marcus Gordon

Name of other Medicaid provider: Merrimack Valley Womens Health Services

Provider no. of other Medicaid provider: 978 38398

Mailing address of other Medicaid provider:

Street address: 9 Branch Street

City: Methuen State: MA Zip: 01844

SECTION 6. ATTESTATION AND RELEASE OF INFORMATION

6.1 Disciplinary, Civil, and Criminal Actions

Questions

1. Have any disciplinary actions been threatened or initiated, or are any disciplinary actions pending against the group or any member of the group by a state licensure board? ☐ yes ☒ no
2. Has the license of any member of the group to practice in any state ever been denied, limited, suspended, revoked, diminished, not renewed, or relinquished (whether voluntarily or involuntarily), or are any proceedings currently pending which may result in any such action? ☐ yes ☒ no
3. Has the medical staff appointment or have privileges of any member of the group ever been limited, suspended, diminished, revoked, refused/denied, terminated, restricted, not renewed, or relinquished (whether voluntarily or involuntarily) at any hospital or health-care facility, or are proceedings currently pending which may result in any such action? ☐ yes ☒ no
4. Has the group or any member of the group ever been suspended, sanctioned, or restricted from participating in any private, federal, or state health program (for example, Medicare, Medicaid, or Blue Cross/Blue Shield)? ☐ yes ☒ no

Please go to the next page. ▶

SECTION 6. ATTESTATION AND RELEASE OF INFORMATION (cont)

5. Does the group or any member of the group have any financial interest (directly or through family or business partners) in any nursing facility, laboratory, pharmacy, medical equipment or supply house or other business to which patients under the group's care might be referred or recommended? ☐ yes ☒ no

6. Have there been any suits or claims against the group or any member of the group alleging malpractice, negligence, failure to diagnose, etc., that are pending or have opened or closed during the past ten (10) years? ☒ yes ☐ no

7. Have any members of the group ever been convicted in a criminal action? Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace, or any conviction of a misdemeanor more that five years before this application if there has been no criminal conviction of any offense within five years of this application. ☐ yes ☒ no

8. Has the group or any member of the group ever been the subject of an inquiry or disciplinary action by any governmental or other regulatory agency or is any such action pending? If yes, include all documentation relating to all inquiries, whether action was taken, dismissed, or pending. Attach a copy of any compliants, responses to complaints, and Board of Registration in Medicine letters. ☐ yes ☒ no

Explanations

If you have answered "yes" to any of the questions above, please provide an explanation and attach all supporting documentation.

Explanations of liability claims, suits or settlements should include names, addresses, and ages of claimants or plaintiffs; the nature and substance of the claim; the date and place at which the claim arose; any amounts paid; the date and manner of disposition, judgment, settlement or otherwise, date and reason for final disposition. If no judgment or settlement, include the patient's condition at the point of your involvement, patient's condition at end of treatment, and the nature and the extent of your involvement with the patient.

Attach additional sheets for each question indicated with a "yes" answer. Please type or print your responses.

Question no. 6

Explain: See Attached Sheet

6.2 Authorization and Release

This recredentialing form is for continued status as a provider in MassHealth. This provider form will become part of (and is incorporated by reference into) the provider contract between this provider and MassHealth.

This provider grants MassHealth permission and consent to obtain and verify information contained in its application for participation in MassHealth and in this recredentialing form and its attachments, and grants consent for any person, organization, or other entity to release to MassHealth all information that may be reasonably relevant to an evaluation of the provider's professional competence or its ability to provide services in a professional manner. The provider understands that participation in MassHealth is dependent upon review of the material contained in and submitted with this form and the completion of the recredentialing process. The provider certifies that the information in its application and in this recredentialing form and its attachments is true, accurate, and complete. The provider further understands that any information entered in its application and in this recredentialing form and its attachments that subsequently is found to be false could result in the termination of the contract.

The person signing below warrants that he or she is an authorized representative of the provider and has the authority to sign on behalf of the provider.

Accepted and agreed to:

Legal name of provider: North Shore Womens Center

Signature of provider or authorized representative: [signature] Date: 7/21/07

Printed name of person signing: Stephanie Lowitt Title of person signing: Prof. Services Dir.

'EDSGRB0748'

93-1003

PC

FPC

Filing Fee: $125.00

Late Fee: $25.00

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

Annual Report for Professional and Foreign Professional Corporations

(General Laws Chapter 156A, Section 18 and Chapter 156D, Section 16.22)

(1) Exact name of the corporation: NORTH SHORE WOMEN'S CENTER, P.C.

(2) Jurisdiction of incorporation: MASSACHUSETTS

(3) Street address of the corporation's registered office in the commonwealth:
480 LYNNFIELD ST., LYNN, MA 01904
(number, street, city or town, state, zip code)

(4) Name of the registered agent at the registered office: MARCUS T. GORDON

(5) Street address of the corporation's principal office:
480 LYNNFIELD ST., LYNN, MA 01904
(number, street, city or town, state, zip code)

(6) Provide the names and addresses of the corporation's board of directors, shareholders, and its president, treasurer, secretary, and if different, its chief executive officer and chief financial officer.

	NAME	ADDRESS
President:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Treasurer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Secretary:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Chief Executive Officer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Chief Financial Officer:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Directors:	MARCUS T. GORDON	1101 BOYLSTON ST., CHESTNUT HILL, MA 02167
Shareholders (with residential address):		

(7) Briefly describe the business of the corporation:
MEDICAL OFFICE

(8-9) Capital stock of each class and series:

CLASS OF STOCK	TOTAL AUTHORIZED BY ARTICLES OF ORGANIZATION OR AMENDMENTS Number of Shares	TOTAL ISSUED AND OUTSTANDING Number of Shares
COMMON	1,000	1,000
PREFERRED		

(10) Check if the stock of the corporation is publicly traded. ☐

(11) Report is filed for fiscal year ending: DECEMBER (month) / 31 (day) / 2006 (year)

It is hereby certified, pursuant to G.L. Chapter 156A, Section 18, that the shareholders, and all the partners of a general partnership which is a shareholder of the corporation are duly licensed to render one or more professional services for which the corporation was organized, or are professional corporations authorized to render such professional services, and that a copy of this report is being sent to the appropriate regulatory board.

Signed by: [signature]

☐ Chairman of the board of directors ☒ President ☐ Other officer ☐ Court appointed fiduciary

on this Sixteenth day of March 2007

c156as18c156as1622 01/13/05

Department of the Treasury
Internal Revenue Service
ANDOVER, MA 05501

Date of this notice: APR. 27, 1998
Taxpayer Identifying Number
Form: Tax Period:

For assistance you may call us at:

617-536-1040
1-800-829-1040

Or you may write to us at the address shown at the left. If you write, be sure to attach the bottom part of this notice.

NORTH SHORE WOMENS CENTER P C
583 CHESTNUT ST
LYNN MA 01904-2600837

NOTICE OF ACCEPTANCE AS AN S-CORPORATION

YOUR ELECTION TO BE TREATED AS AN S-CORPORATION WITH AN ACCOUNTING PERIOD OF DECEMBER IS ACCEPTED. THE ELECTION IS EFFECTIVE BEGINNING FEB. 23, 1998, SUBJECT TO VERIFICATION IF WE EXAMINE YOUR RETURN.

IF YOUR EFFECTIVE DATE IS NOT AS REQUESTED, IT WILL HAVE BEEN CHANGED FOR ONE OF TWO REASONS. EITHER YOUR ELECTION WAS MADE AFTER THE 15TH DAY OF THE THIRD MONTH OF THE TAX YEAR TO WHICH IT APPLIES, BUT BEFORE THE END OF THAT TAX YEAR, OR THE ELECTION WHEN SUBMITTED WAS INCOMPLETE, AND REQUESTED INFORMATION WAS RECEIVED AFTER THE FILING PERIOD. IN EITHER CASE, YOUR ELECTION IS INVALID FOR THE TAX YEAR REQUESTED AND HAS THEREFORE, BEEN TREATED AS THOUGH IT WERE MADE FOR THE NEXT TAX YEAR.

PLEASE KEEP THIS NOTICE IN YOUR PERMANENT RECORDS AS VERIFICATION OF YOUR ACCEPTANCE AS AN S-CORPORATION.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR THE ACTIONS WE HAVE TAKEN, PLEASE WRITE TO US AT THE ADDRESS SHOWN ABOVE. IF YOU PREFER, YOU MAY CALL US AT THE IRS TELEPHONE NUMBER LISTED IN YOUR LOCAL DIRECTORY. AN EMPLOYEE THERE MAY BE ABLE TO HELP YOU; HOWEVER, THE OFFICE AT THE ADDRESS SHOWN ON THIS NOTICE IS MOST FAMILIAR WITH YOUR CASE.

IF YOU WRITE TO US, PLEASE PROVIDE YOUR TELEPHONE NUMBER AND THE MOST CONVENIENT TIME FOR US TO CALL SO WE CAN CONTACT YOU TO RESOLVE YOUR INQUIRY. PLEASE RETURN THE BOTTOM PART OF THIS NOTICE TO HELP US IDENTIFY YOUR CASE.

THANK YOU FOR YOUR COOPERATION.

To make sure that IRS employees give courteous responses and correct information to taxpayers, a second IRS employee sometimes listens in on telephone calls

Overlay 5 Form 8489 (Rev.8-91)

Keep this part for your records

Return this part to us with your check or inquiry

Your telephone number	Best time to call
( ) -	

INTERNAL REVENUE SERVICE
ANDOVER, MA 05501

NORTH SHORE WOMENS CENTER P C
583 CHESTNUT ST
LYNN MA 01904-2600837

Examiner

Name Approved

PC

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

ARTICLES OF ORGANIZATION
(General Laws, Chapter 156A)

ARTICLE I
The exact name of the corporation is:

North Shore Women's Center, P.C.

ARTICLE II
The purpose of the corporation is to engage in the following business activities:

The practice of medicine, including the performance of all medical and related services, through officers, employees, and agents duly registered and licensed to practice the profession of medicine within the Commonwealth of Massachusetts, together with ancillary and collateral non-professional services rendered by employees not professionally qualified but working under the supervision of professionally qualified officers or employees;

To own real and personal property necessary or appropriate for the rendering of medical and related services; to invest in real estate, mortgages, stocks, bonds, or any other type of investment;

To do or cause to be done any and all such acts and things as may be necessary, desirable, appropriate, convenient, or incidental to the accomplishment or performance of any or all of the foregoing purposes;

and

To engage in any lawful act or activity for which professional corporations may be organized under Massachusetts Professional Corporation Laws.

C ☐
P ☑
M ☐
R.A. ☑

SS 5x035

8

P.C.

Note: If the space provided under any article or item on this form is insufficient, additions shall be set forth on one side only of separate 8 1/2 x 11 sheets of paper with a left margin of at least 1 inch. Additions to more than one article may be made on a single sheet so long as each article requiring each addition is clearly indicated.

ARTICLE III

State the total number of shares and par value, if any, of each class of stock which the corporation is authorized to issue:

WITHOUT PAR VALUE		WITH PAR VALUE		
TYPE	NUMBER OF SHARES	TYPE	NUMBER OF SHARES	PAR VALUE
Common:		Common:	200,000	$0.01
Preferred:		Preferred:		

ARTICLE IV

If more than one class of stock is authorized, state a distinguishing designation for each class. Prior to the issuance of any shares of a class, if shares of another class are outstanding, the corporation must provide a description of the preferences, voting powers, qualifications, and special or relative rights or privileges of that class and of each other class of which shares are outstanding and of each series then established within any class.

NONE

ARTICLE V

The restrictions, if any, imposed by the Articles of Organization upon the transfer of shares of stock of any class are:

Stock of the corporation shall be issued in accordance with Section 1244 of the Internal Revenue Code, or its successor sections.

See Continuation Sheet 5A attached hereto and incorporated by reference.

ARTICLE VI

**Other lawful provisions, if any, for the conduct and regulation of the business and affairs of the corporation, for its voluntary dissolution, or for limiting, defining, or regulating the powers of the corporation, or of its directors or stockholders, or of any class of stockholders:

The Directors may amend or repeal the by-laws in whole or in part except with respect to any provision(s) thereof which by law or under the by-laws requires action by shareholders.

See Continuation Sheet 6A attached hereto and incorporated by reference.

** *If there are no provisions state "None".*
Note: The preceding six (6) articles are considered to be permanent and may only be changed by filing appropriate Articles of Amendment.

CONTINUATION SHEET 5A

Any stockholder, including the heirs, assigns, executors or administrators of a deceased stockholder, desiring to sell or transfer such stock owned by him or them, shall first offer it to the professional corporation through the Board of Directors, in the manner following:

He shall notify the directors of his desire to sell or transfer by notice in writing, which notice shall contain the price at which he is willing to sell or transfer and the name of one arbitrator. The directors shall, within thirty days thereafter, either accept the offer, or by notice to him in writing, name a second arbitrator, and these two shall name a third. It shall then be the duty of the arbitrators to ascertain the value of the stock, and if any arbitrator shall neglect or refuse to appear at any meeting appointed by the arbitrators, a majority may act in the absence of such arbitrator.

After the acceptance of the offer, or the report of the arbitrators as to the value of the stock, the directors shall have thirty days within which to purchase the same at such valuation, but if at the expiration of thirty days, the professional corporation shall not have exercised the right so to purchase, the owner of the stock shall be at liberty to dispose of the same in any manner he may see fit.

No shares of stock shall be sold or transferred on the books of the professional corporation until these provisions have been complied with, but the Board of Directors may in any particular instance waive the requirement.

A shareholder may transfer shares and rights or options to purchase shares of the professional corporation only to qualified persons as defined in Massachusetts General Laws Chapter 156A. Subject to Sections 12 and 13 of said Chapter 156A, nothing contained herein shall prohibit the pledge of shares of the professional corporation to a disqualified person or the transfer of such shares by operation of law or court decree to a disqualified person.

Every certificate issued representing shares of this professional corporation shall state thereon in bold print that the shares represented thereby are subject to restrictions on transfer imposed by Massachusetts General Laws Chapter 156A and any further restrictions on transfer imposed by the Board of Registration in Medicine from time to time pursuant to said Chapter.

CONTINUATION SHEET 6A

6. Other lawful provisions for the conduct and regulation of the business and affairs of the professional corporation, for its voluntary dissolution, or for limiting, defining or regulating the powers of the professional corporation, or of its directors or stockholders, or any class of stockholders:

(a) The directors may make, amend or repeal the By-Laws in whole or in part, except with respect to any provision thereof which by law or in accordance with the terms of the By-Laws require action by the stockholders.

(b) Meetings of the stockholders may be held anywhere in the United States.

(c) The professional corporation may be a partner in any business enterprise it would have power to conduct by itself.

(d) The directors shall have the power to fix from time to time their compensation. No person shall be disqualified from holding any office by reason of any interest. In the absence of fraud, any director, officer or stockholder of this professional corporation, or any concern which is a stockholder of this professional corporation individually, or any individual having any interest in any concern which is a stockholder of this professional corporation, or any concern in which any such directors, officers, stockholders or individuals have any interest, may be a party to, or may be pecuniarily or otherwise interested in, any contract, transaction or other act of this professional corporation, and

(1) such contract, transaction or act shall not be in any way invalidated or otherwise affected by that fact;

(2) no such director, officer, stockholder or individual shall be liable to account to this professional corporation for any profit or benefit realized through any such contract, transaction or act; and

(3) any such director of this professional corporation may be counted in determining the existence of a quorum at any meeting of the directors or of any committee thereof which shall authorize any such contract, transaction or act, and may vote to authorize the same.

The term "interest" shall include personal interest and interest as a director, officer, stockholder, shareholder, trustee, member or beneficiary of any concern.

The term "concern" shall mean any corporation, association, trust, partnership, firm, person or other entity other than this professional corporation.

(e) No Director shall be personally liable to the professional corporation or any stockholder for monetary damages for breach of fiduciary duty as a director, except for any matter in respect of which such director shall be liable under Sections 61 and 62 of Chapter 156B of the Massachusetts General Laws or any amendment thereto or successor provision thereto or shall be liable by reason that, in addition to any and all other requirements for such liability, he (i) shall have breached his duty of loyalty to the professional corporation or its stockholders, (ii) shall not have acted in good faith or, in failing to act, shall not have acted in good faith, (iii) shall have acted in a manner involving intentional misconduct or knowing violation of law, or (iv) shall have derived an improper personal benefit. Neither the amendment nor repeal of this paragraph shall eliminate or reduce the effect of this paragraph in respect of any matter occurring, or any cause of action, suit or claim that, but for this paragraph would accrue or arise, prior to such amendment, repeal or adoption of an inconsistent provision.

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

CERTIFICATE BY REGULATORY BOARD
(General Laws, Chapter 112 or 221)

In compliance with General Laws, Chapter 156A, Section 7, the Board of Registration in Medicine
(Exact name of board)

hereby certifies that in connection with the incorporation of North Shore Women's Center, P.C.
(Exact name of corporation)

a professional corporation formed to render medical services,
(Type of professional service to be rendered)

the below listed incorporators, officers, directors, and shareholders are duly licensed or admitted to practice the profession listed above.

INCORPORATORS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

OFFICERS	RESIDENTIAL ADDRESS
President: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167
Treasurer: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167
Clerk: Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

DIRECTORS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

SHAREHOLDERS	RESIDENTIAL ADDRESS
Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167

SIGNED this 19th day of February, 19 98,

by _____, *Chairman / *Clerk.

*Delete the inapplicable word.

ARTICLE VII

The effective date of organization of the corporation shall be the date approved and filed by the Secretary of the Commonwealth. If a *later* effective date is desired, specify such date which shall not be more than thirty days after the date of filing.

ARTICLE VIII

The information contained in Article VIII is not a permanent part of the Articles of Organization.

a. The street address (post office boxes are not acceptable) of the principal office of the corporation *in Massachusetts* is:

583 Chestnut Street, Lynn, MA 01904

b. The name, residential and post office address of each director, officer and shareholder of the corporation is as follows:

	NAME	RESIDENTIAL ADDRESS	POST OFFICE ADDRESS
President:	Marcus T. Gordon, M.D.	1101 Boylston Street, Chestnut Hill, MA 02167	
Treasurer:	Marcus T. Gordon, M.D.	-- same --	
Clerk:	Marcus T. Gordon, M.D.	-- same --	
Directors:	Marcus T. Gordon, M.D.	-- same --	
Shareholders:	Marcus T. Gordon, M.D.	-- same --	

c. The fiscal year of the corporation shall end on the last day of the month of: December

d. The name and business address of the resident agent, if any, of the corporation is:

Colin A. Coleman, Esq., P.O. Box 915, 20 Pickering Street, Needham, MA 02192

Please insert the required certificate(s) from the appropriate regulatory board(s).

ARTICLE IX

By-laws of the corporation have been duly adopted and the president, treasurer, clerk and directors whose names are set forth above, have been duly elected.

IN WITNESS WHEREOF AND UNDER THE PAINS AND PENALTIES OF PERJURY, I/we, whose signature(s) appear below as incorporator(s) and whose name(s) and business or residential address(es) *are clearly typed or printed* beneath each signature do hereby associate with the intention of forming this corporation under the provisions of General Laws, Chapter 156A and do hereby sign these Articles of Organization as incorporator(s) this 11th day of February, 19 98.

Marcus T. Gordon, M.D., Incorporator

583 Chestnut Street, Lynn, MA 01904

Note: If an existing corporation is acting as incorporator, type in the exact name of the corporation, the state or jurisdiction where it was incorporated, the name of the person signing on behalf of said corporation and the title he/she holds or other authority by which such action is taken.

607186

THE COMMONWEALTH OF MASSACHUSETTS

98 FEB 23 AM 11:00

CORPORATION DIVISION

ARTICLES OF ORGANIZATION

(General Laws, Chapter 156A)

I hereby certify that, upon examination of these Articles of Organization, duly submitted to me, it appears that the provisions of the General Laws relative to the organization of corporations have been complied with, and I hereby approve said articles; and the filing fee in the amount of $ 200.00 having been paid, said articles are deemed to have been filed with me this 23rd day of FEBRUARY 19 98

Effective date: _____

William Francis Galvin

WILLIAM FRANCIS GALVIN

Secretary of the Commonwealth

FILING FEE: One tenth of one percent of the total authorized capital stock, but not less than $200.00. For the purpose of filing, shares of stock with a par value less than $1.00, or no par stock, shall be deemed to have a par value of $1.00 per share.

TO BE FILLED IN BY CORPORATION

Photocopy of document to be sent to:

Alice B. Taylor, Esq.
Colin A. Coleman & Associates
20 Pickering Street; P.O. Box 915
Needham, MA 02192

Telephone: 781-444-2333

Form **W-9**
(Massachusetts Substitute W-9 Form)
Rev. May 2004

Request for Taxpayer Identification Number and Certification

Completed form should be given to the requesting department or the department you are currently doing business with.

Please print or type

Name (List legal name, if joint names, list first & circle the name of the person whose TIN you enter in Part I-See Specific Instruction on page 2)

North Shore Women's Center PC

Business name, if different from above. (**See Specific Instruction** on page 2)

Check the appropriate box: ☐ Individual/Sole proprietor ☒ Corporation ☐ Partnership ☐ Other ▶

Legal Address: number, street, and apt. or suite no.	**Remittance Address**: if different from legal address number, street, and apt. or suite no.
480 Lynnfield st	Same
City, state and ZIP code	**City, state and ZIP code**
Lynn, MA 01904	

Phone # (781) 595 4800 Fax # (781) 595 3843 Email address:

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instruction on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.
Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
☐☐☐-☐☐-☐☐☐☐
OR
Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Services (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am an U.S. person (including an U.S. resident alien).
4. I am currently a Commonwealth of Massachusetts's state employee: (check one): No ✓ Yes _____ If yes, attach a copy of the letter from the State Ethics Commission. Individual information, including address will be part of the public record and accessible under Freedom of Information.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply.

Sign Here | **Authorized Signature** ▶ [signature] **Date** ▶ 7/26/07

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and , when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued).
2. Certify you are not subject to backup withholding

If you are a foreign person, use the appropriate Form W-8. See **Pub 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding? Persons making certain payments to you must withhold a designated percentage, currently 29% and pay to the IRS of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions on page 2.

Penalties

Failure to furnish TIN. If your fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Part I - Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5**, Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7**, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or **Form SS-4**, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS's Internet Web Site { **HYPERLINK http://www.irs.gov** }.

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments.

The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.*

Part II - Certification

To establish to the paying agent that your TIN is correct or you are a U.S. person, or resident alien, sign Form W-9.

For a joint account, only the person whole TIN is shown in Part I should sign (when required).

Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold a designated percentage, currently 29% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number to Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4]. List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

If you have questions on completing this form, please contact the Office of the State Comptroller. (617) 973-2311 or 973-2655

Upon completion of this form, please send it to the Commonwealth of Massachusetts Department you are doing business with.

36 1005482803 0070

The [illegible] Massachusetts

REGISTRATION

In Accordance with Massachusetts General Laws Chapter 94C

NUMBER

ISSUED
07/14/06

TYPE
CONTROLLED SUBSTANCES PRACTITIONER

SCHEDULES
II,III,IV,V,VI

ISSUED TO

GORDON, MARCUS T MD
480 LYNNFIELD STREET
LYNN, MA 01904

COMMISSIONER OF PUBLIC HEALTH

374653

RECIPIENT S[illegible]

RECALL

165025

PEC Indexing Cover Sheet

Receipt Date: 2/22/10 Clerk: JS ☐ New Enrollment ☑ Update

Document Type:

☐ Provider Enrollment Application Wet Signature ☐ Yes ☐ No	☐ Recredentialing Application	☐ Request for Disenrollment	☐ Request for Changes to Provider Data *(Including Application DCFs)*	☐ Managed Care Contract *(PCC App)* Wet Signature ☐ Yes ☐ No ***[first 2 pages only]***	☐ W-9 Wet Signature ☐ Yes ☐ No ***[first page only]***
☐ Party-in Interest Information	☐ Tax-ID Verification (Tax Coupon, Notice of EIN)	☐ Corporation - Articles of Incorporation / Annual Report / Fed. Tax Return / Financial Stmts.	☐ Partnership - Cert. of MA Ltd Partnership / Partnership Agreement / Tax Return / Fin. Stmts.	☐ Trust - Declaration of Trust / Fed. Tax Return / Financial Stmts.	☐ Medicare EOMB
☐ DME Eligibility Documents	☐ Collaborative Arrangements (Nurse Practitioners or Nurse Midwives	☐ Proof of Insurance	☐ Provider Application request	☐ Provider Contract (*Provider Agreement*) Wet Signature ☐ Yes ☐ No	☐ Managed Care Application Request
☐ EFT request *(Request Changes)* Wet Signature ☐ Yes ☐ No ***[form only]***	☐ Certifications *(Includes NPI)*	☐ Other Accreditations Wet Signature ☐ Yes ☐ No	☐ DEA Certificate	☐ Controlled Substance Certificate	☐ Dental Partnering Agreement
☐ 304B Subcontractor Agreement	☐ ISA	☐ Request for Application for Hospitals (RFA)	☐ Licenses	☐ Wheelchair Van Special Conditions Agreement	☐ Application Updates
☐ TPA	☐ (Missing information) Correspondence	☑ Provider Correspondence *(Including Non-Application DCFs)*	☐ Member Correspondence	☐ Reject	☐ Outreach Required

SSN / FEIN: _____

Provider Type: 01

ATN: _____ Old ATN (If applicable)_____

Provider #: _____

Optional Fields

Provider Last Name: _____

Provider First Name: _____

Facility Name: _____

Rev (3) 4-23-09

DS