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MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Update Form for Facilities

Questions? Call 1-800-316-BLUE (2583)

Send form to BlueCrossNetworkContracting@bcbsma.com or fax 617-246-6819

Use this form to notify Blue Cross* of changes to a contracted provider's status. If needed, we'll send an amendment or new agreement for signature. Please allow 30 business days for processing.

To ensure legibility, please complete this form online. Keep a copy of the completed form for your records.

We will notify you of the effective date of your requested update. Until then, you cannot be reimbursed for the newly requested service, site, or Product.

Check your Blue Cross contract type: (required)

- ❑ Ambulatory Surgi-Center ♦
- ❑ Assisted Reproductive Technology ♦
- ❑ Behavioral Health Facility ♦
- ❑ Behavioral Health Hospital ♦
- ❑ Chronic or Long Term Care Hospital ♦
- ❑ Community Mental Health Center ♦
- ❑ Durable Medical Equipment
- ❑ Early Intervention Program ♦
- ❑ Freestanding Cardiac Rehabilitation Center
- ❑ Freestanding Clinical Laboratory ♦
- ❑ Freestanding Dialysis Facility
- ❑ Freestanding Radiation Oncology Facility
- ❑ Freestanding Sleep Study Facility/Out of Center Testing ♦
- ❑ Ground Ambulance
- ❑ Home Health Care ♦
- ❑ Home Infusion Therapy ♦
- ❑ Hospice Services
- ❑ Independent Physiologic and Diagnostic Laboratory
- ❑ Opioid Treatment Program ♦
- ❑ Rehabilitation Hospital ♦
- ❑ Skilled Nursing Facility ♦
- ❑ Technical Diagnostic Imaging ♦
- ❑ Transitional Care Unit ♦
- ❑ Urgent Care Center ♦

♦ This symbol means that if you are opening or relocating a service site, you must **also** complete a *Provider Application* for that site to be credentialed. See page 3.

Check all that apply and complete required sections:	**Required sections:**	
❑ You are opening, closing, or relocating service sites	1, 2, 6, 9	♦ See note above
❑ You want to add a Product to your agreement	1, 2, 5, 6, 8, 9	
❑ You are changing your tax ID number	Please complete a new *Provider Application* **instead** of this form and explain this change on p. 2 under "Blue Cross non-contracted provider number"	
❑ You have an organization change, such as a new business name or change in ownership	1, 2, 4, 8, 9	
❑ You have a new business address or billing address	1, 3, 6, 9	
❑ You are changing the services you provide	1, 2, 6, 7, 9	If a BH Hospital, BH Facility, or Community Mental Health Center: You must also submit the *Child Behavioral Health Services form*
❑ You are recontracting with Blue Cross	1, 2, 3, 5, 6, 8, 9	
❑ Your organization is ceasing business or will no longer provide services in Massachusetts	1, 4, 9	
❑ Other (please describe)		

Section 1. Current organization information

Provider's legal name	
DBA name (**as it appears on the W-9**)	
National Provider Identifier (NPI type 2) for your contract type checked above	
Tax ID number	
Medicare participating number	

Section 2. Authorized signer

As part of our efforts to improve the contracting process, we use electronic signature. The sender will be echosign@echosign.com or *Adobe Sign*. Check your spam or junk mail folder to make sure you've added this address as a trusted sender.

If we need to send you an amendment or a new contract for signature, we must email it directly to someone authorized to sign on behalf of your organization or practice, such as *owner, partner, president*.

Authorized signer's name	Business title	Email (required)

If you want someone cc'd, please provide their email

Section 3. New business location

New main business location – where we should mail certain legal notices

Street address			
City, state, ZIP			
Phone to schedule appointments		Fax	

New billing address – your pay-to address

Billing name			
Address			
City, state, ZIP			
Email			
Phone		Fax	

Section 4. New organization information

Please check the type of change:

❑ Purchase, acquisition, or merger — Effective date

Fax a **formal notice** on your letterhead along with an IRS Form W-9. We will send a consent to assignment for signature by your organization, and by the new owner if any.

If your organization's name or tax ID is changing, we will send you a new contract, but first you will need to complete a *Provider Application* to be credentialed under the new name.

If applicable, please provide the email address of someone authorized to sign contracts on behalf of the ***assignee***:

❑ Legal name change only — Effective date

By checking this box, you affirm there are no organizational changes underlying the change in legal name, and that your organization's Tax ID, NPI, Medicare, and MassHealth numbers (as applicable) are not changing. Indicate the effective date above and attach an IRS Form W-9 with your new name. We will send an amendment for your signature.

❑ DBA name change – attach an IRS Form W-9 with your new DBA name — Effective date

❑ Ceasing business or other (please describe) — Effective date

Section 5. Product participation

Check **all** Blue Cross Products you want to participate in: ❑**All Products**

❑HMO ❑PPA/PPO ❑Indemnity ❑Medicare Advantage HMO ❑Medicare Advantage PPO

Section 6. Service sites

To ensure the accuracy of our records, **please list ALL SERVICE SITES — both current and new —** where you will provide services. Copy this page if you need more space for additional sites.

1. If your facility is relocating its **only service site**, you must: (a) submit this Update Form **and** (b) complete a Provider Application to credential the new site.
2. If you are **opening a new site or relocating a site** and this symbol ♦ is next to your contract type on page 1, you must:
   (a) submit this form to give us a list of all your current sites **and** (b) complete an application and attach required documentation applicable to the new site.

The *Provider Application* is available on Provider Central at **Forms>Contracting Applications**.

Service site #1 ❑Currently contracted site ❑New site ❑Closing site Effective date

Site name

Address

City, state, ZIP

NPI* Medicare participating #* MassHealth #*

Service site #2 ❑Currently contracted site ❑New site ❑Closing site Effective date

Site name

Address

City, state, ZIP

NPI* Medicare participating #* MassHealth #*

Service site #3 ❑Currently contracted site ❑New site ❑Closing site Effective date

Site name

Address

City, state, ZIP

NPI* Medicare participating #* MassHealth #*

* Include number if it is unique for this site.

Section 7. New service

If your facility plans to offer a new specialty service, please describe.

Section 8. IRS Form W-9

❑ To verify new billing information, please attach a signed and dated IRS Form W-9 showing the legal name and tax ID number *to which payments should be directed*.

Section 9. Representations

❑ *By checking this box, I hereby affirm and represent that all statements, answers, and information included in this Update Form are true and complete to the best of my knowledge and belief, and that I am duly authorized to provide information on behalf of the organization or practice named in section 1.*

Name of person completing form

Business title

Email (required) Phone

Date

* Blue Cross refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc., and/or Massachusetts Benefit Administrators LLC, based on Product participation. ®Registered Mark of the Blue Cross Blue Shield Association.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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 Service (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 a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*