MASSACHUSETTS

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

Birth Center Application

Fax this form with the requested documentation to 617-246-6819 or email to *BlueCrossNetworkContracting@bcbsma.com*.

Please review the global and provider type credentialing requirements at www.bluecrossma.com/provider. Do not apply unless you meet these requirements.

About our evaluation of this application

Blue Cross* will evaluate this application according to its completeness and the organization's ability to meet pre-established credentialing criteria and network need, as determined solely by Blue Cross.

We reserve the unqualified right to reject any and all applications, subject to the terms of this application and applicable law.

By accepting this application for evaluation, we agree that any patient-specific or identifying information, any non-publicly available information that you designate as confidential set forth in this application, and any non-publicly available information that is obtained in the application process will remain confidential unless its release is required or permitted by law, regulation, or valid court order.

We will notify you of the credentialing decision within 60 days, using the main business address on page 2.

The following information collected for credentialing purposes will be available for your review:

- Information submitted in this application and supporting documents.
- Certain information we collect from outside primary sources, such as malpractice insurance carriers and state licensing boards.

If we approve this application, we will send an agreement for your signature. You may contact us about the status of your participation at ProviderApplicationStatus@bcbsma.com or 1-800-316-BLUE (2583).

Supporting documentation

Please attached a copy of the following as they relate to your organization (and for each site, if different). All documents must be current as of the date your agreement becomes effective.

- A copy of your clinic or hospital license

  Note: If your license has expired, a Chapter 30A letter from the Massachusetts Department of Public Health (DPH) is required.
- A signed and dated IRS Form W-9 showing the name and Tax ID number to which payments should be directed. A blank form is attached for your convenience.
- Accreditation certificate from one of the following:
  - Council on Accreditation (COA)
  - The Joint Commission (TJC)
  - American Association of Birth Centers (AABC)
  - Commission for the Accreditation of Birth Centers (CABC)
- Medical Director's board certification and license
- Roster of clinicians: You will need to list the clinicians rendering services to Blue Cross members and their identifying numbers.

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* 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.

Organization information

Provider's legal name

DBA (**as it appears on the W-9**)

Tax ID number

Check if you attached a signed and dated IRS Form W-9 ☐

National Provider Identifier (NPI type 2)

Blue Cross non-contracted provider number (if any)

Do you participate in MassHealth?

- ☐ Yes – enter current MassHealth participating provider number
  - and enter effective date of participation
- ☐ Pending – enter date you applied for MassHealth participation
- ☐ No

Main business location

Address

City, state, ZIP

Phone Fax

Management or parent company

Management or parent company name

Address

City, state, ZIP

Phone Fax

Authorized signatory

To process your agreement efficiently, we use electronic signature. If we approve this application for a new contract, we must email your agreement **directly to someone authorized to sign contracts** on behalf of your organization, such as *owner, partner, president*. **It cannot be forwarded for signature.**

The sender will be Adobe Sign <echosign@echosign>.

Name of authorized signer	**Title**	**Email** Required

If you would like anyone cc'd for review, please provide their email

Product participation

Check the Blue Cross Products you want to participate in:

☐ All Products - or - ☐ HMO ☐ PPA/PPO ☐ Indemnity

Service information

List the hospitals and/or physician groups that refer to your organization.

What is unique about your organization? List specific reasons why your organization would benefit our members.

Attestations

Please check boxes below to affirm each statement.

Claims submission

Your organization must begin submitting claims electronically within 90 days of your contract effective date, or we have the option to terminate your agreement.

☐ *Our organization is able to submit claims electronically*

Communications

You must become a registered, active user of our secure website, http://www.bluecrossma.com/provider, to access the latest fee schedules, forms, policies, contractual notices, and other communications. You (or your organization) will need to keep your e-mail address current, so we can send you important notices.

If we contract with you, your welcome letter will include instructions on how to register for our website.

☐ *Our organization agrees to comply with this requirement*

Reimbursement

We use e-payment as our standard method of payment for provider reimbursement, at no cost to our providers. E-payment is a secure online direct deposit into your bank account that occurs via electronic funds transfer (EFT). Enrolling in e-payment offers an additional benefit of online access to your payment advisories. You will need to register for and use Payspan® (an electronic tool for EFT and online advisories) to get reimbursement for services rendered to our members.

☐ *Our organization agrees to comply with this requirement*

Where should we email instructions on how to register for Payspan?

License and malpractice history

In the following questions, "you" and "your" refer to the applicant organization/facility/program and its officers, partners, medical directors, and other principals. For each "yes" answer, please attach a detailed explanation.

1	Have any judgments been awarded against you or settlements made by you or on your behalf?	☐Yes	☐No
2	Has your license to practice ever been denied, limited, suspended, or revoked, or otherwise subject to any conditions in any jurisdiction?	☐Yes	☐No
3	Have you ever been disciplined, suspended, or terminated by any government or private third-party payer (for example, Medicare or MassHealth)?	☐Yes	☐No
4	Are any formal disciplinary charges pending, against you or your clinical employees, before any licensing authority in Massachusetts or elsewhere?	☐Yes	☐No
5	Have you ever pled guilty to or been convicted of a felony?	☐Yes	☐No
6	Have you ever been the subject of any Blue Cross Blue Shield, Medicare, MassHealth/Medicaid, or any other medical reimbursement plan suspension or probation proceedings, or ever been restricted from receiving payments from any Blue Cross Blue Shield, Medicare, Medicaid (any state), or other third-party program?	☐Yes	☐No
7	Have you had a participating provider application rejected by any HMO, PPO, or other prepaid health care plan?	☐Yes	☐No
8	Have you ever had a participating provider contract terminated by any HMO, PPO, or other prepaid health care plan?	☐Yes	☐No

Medical director

The medical director must be a certified nurse-midwife, an obstetrician, or a family practitioner with obstetrical privileges at a Plan-participating acute care hospital with labor and delivery services.

Hospital-affiliated Birth Centers: If the affiliated hospital does not provide obstetrics and newborn services, the medical director must meet the requirements set forth in 105 CMR 142.501(B).

Your medical director must:

- have a current, valid, and unrestricted Massachusetts medical license
- be credentialed by and contracted with Blue Cross Blue Shield of Massachusetts whether or not providing direct patient care.

Name		NPI Type 1	
License number			

Check if you attached copies of the medical director's license (and board certification if applicable) ☐

Clinical roster

Only clinicians separately contracted with Blue Cross Blue Shield of Massachusetts under a physician or professional agreement may render services to our members.

Please list all clinicians who render services.

First name	**Last name**	**NPI Type 1**	**Does clinician already participate with BCBSMA?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
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			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Service site information

Copy and complete pages 5 and 6 for every licensed location where you will provide services to our members.

By checking this box, I acknowledge that my organization must immediately submit an Update Form when there are changes to any of the service site information below. ☐

Service site

Site # **of** **(total number of service sites)**

Site name
Address
City or town, state, ZIP
Phone to schedule appointments Fax
NPI for this service site, if different

Billing address

Same as… ☐ Service site ☐ Main business location ☐ Management/parent company ☐ Other:

Billing company name
Address 1
Address 2
City or town, state, ZIP
Phone Fax

Accessibility

Does this site accept admissions, provide services, or have a coverage arrangement:
24 hours a day, 7 days per week? ☐ Yes ☐ No
During evening hours? ☐ Yes ☐ No
On weekends? ☐ Yes ☐ No

Which Massachusetts counties are in this site's service area?

Is this site handicap accessible (i.e., parking, ramps, or elevator)? ☐ Yes ☐ No
Does this site have TTY/TDD services for people with hearing impairments? ☐ Yes ☐ No
If yes, please provide number
Is this site accessible by public transportation? ☐ Yes ☐ No
Are interpretation services available at this site? ☐ Yes ☐ No
Which foreign languages (including sign language) are spoken by an office interpreter at this site?

License for this site

Check if you attached a copy of your license ☐

Check if the number below and license attached for Site #1 applies to all sites ☐

License number Type of license: ☐ Clinic ☐ Hospital

If your license has expired, check if you attached a copy of your Chapter 30A letter from the Massachusetts DPH ☐

2nd page for **Site #** ☐

Accreditation for this site

Check if you attached certificate(s) for the accreditation indicated below ☐

Check if the accreditation information below and certificate attached for Site #1 applies to all sites ☐

Please indicate your accreditation:

Council on Accreditation (COA)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

The Joint Commission (TJC)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

American Association of Birth Centers (AABC)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

Commission for the Accreditation of Birth Centers (CABC)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

Insurance information for this site

Check if insurance information entered for Site #1 applies to all sites ☐

Present malpractice carrier

Name

Dates of coverage From To

Present liability carrier

Name

Dates of coverage From To

Representations

Please read the following statements. You must sign and date this section before submitting your application for a new contract.

By my signature below, I represent and warrant that I am duly authorized to complete this application on behalf of the applicant named above (the "provider").

I understand that Blue Cross will re/credential participating providers pursuant to various requirements, including, but not limited to, credentialing requirements, contractual obligations, and/or regulatory requirements. My signature below will serve as a release and waiver to allow Blue Cross to access relevant information for purposes of credentialing and any quality concerns.

I hereby signify the provider's willingness, if requested, to participate in site visits performed by Blue Cross or a Blue Cross designee, and authorize representatives of Blue Cross or its agents to consult with any health care facilities, employers, persons, or entities with whom the provider is or has been associated, including, but not limited to, the provider's malpractice carriers, the National Practitioner Data Bank, relevant accrediting entities, and the appropriate state licensing board, that may have information pertinent to the provider's qualifications and this application; provided, however, that such authorization does not constitute authorization of the disclosure of communications or information subject to attorney-client or peer review privileges.

I release from any liability all representatives of Blue Cross for any acts performed in good faith in connection with the evaluation of this application. I release from any liability all individuals and organizations that provide information to Blue Cross in good faith concerning the provider's qualifications pertaining to this application, including otherwise privileged or confidential information disclosed pursuant to the above authorization.

I hereby affirm and represent that all statements, answers, and information in this application are true and complete to the best of my knowledge and belief.

I understand and agree that:

- I have the burden to produce adequate information to permit evaluation of the provider's qualifications and for resolving any doubts about such qualifications.
- Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.
- The provider cannot provide covered services and be reimbursed as a participating provider until notified by Blue Cross that the provider's contract is in effect, at which time this application will become part of the contract.
- If the provider is accepted for participation by Blue Cross, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.
- The provider must immediately submit an *Update Form* to Blue Cross when there are changes to any information in this application.
- Any misrepresentation or omission will be sufficient cause for immediate, unilateral termination by Blue Cross of any Blue Cross provider agreement.

This authorization and release will be in effect upon the submission of this application and will remain in effect through the term of any ensuing provider contract.

Accepted and agreed to by

Signature	
Print name of person completing form	
Title	
Company name	
Email Required	
Date	

If we send you a contract, please remember that only the authorized persons you have identified may sign.