Print form Clear form fields

Audiologist, Chiropractor, Optometrist, Licensed Dietitian Nutritionist

Contracting Application

MASSACHUSETTS

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

Questions? Read our Contracting Q & As.

Complete this form online. Leaving blanks will delay processing.

Send completed form to *BlueCrossContractOps@bcbsma.com* or fax 617-246-5053.

If emailing, please include practitioner's *Last Name, First Name* in the Subject.

Blue Cross* will evaluate this application according to your 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.

Please do not apply unless you meet the global and provider type credentialing requirements.
The requirements can be viewed at bluecrossma.com/provider in Office Resources>Enrollment>Credentialing & Recredentialing>Credentialing.

Each practitioner must complete the online application through the Council for Affordable Quality Healthcare (CAQH) website at https://proview.caqh.org.

If...	Then...
You're already a CAQH provider	• Update all information (including expired documents). • Choose the option to authorize all healthcare organizations. This will allow us to access your information.
You're not a CAQH provider	• Log onto the CAQH website and self-register. • Once registered, thoroughly complete your *Integrated Massachusetts Application* and submit all required documents.
You're not sure of your status	Call CAQH at 1-888-599-1771.

Please check one:

- ☐ **I am joining a group practice**
  - I am new to Blue Cross and joining a practice or facility that submits claims on a CMS-1500 or 837P
- ☐ **I am contracting as a solo provider**
  - I bill under a Social Security Number or a Federal Tax Identification Number (EIN) as a sole proprietor, AND
  - I do not currently reimburse any practitioners for services.

Each new group or solo practice must also attach:

- A completed Practice Application (beginning on page 6) - submit only once per practice
- An IRS Form W-9 that is signed, dated, and completed with the name and Tax ID Number (EIN) to which payments will be made. We cannot process your request without a W-9. A form is attached.

Practitioner information

Your provider type (check one only):

Audiologist: q **MS** q **MA** q **PhD** q **AuD** q **Other** ______________________________

q **Chiropractor (DC)** q **Licensed Dietitian Nutritionist (LDN)** q **Optometrist (OD)**

First name	
Last name	
National Provider Identifier (NPI Type 1)	
Social security number	
Date of birth	
Massachusetts license number	
New Hampshire license number	

Practice location information

Practice locations are where patients can make an appointment to see you. Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Employment or start date at this practice (month/day/year) ______________________________

This practice will be your: q **Primary practice** q **Secondary practice**
(If you are not the practitioner, please verify before making a selection)

Main practice location

Practice name (legal name)	
DBA (if reported to the IRS)	
Practice's tax ID number	
Practice's NPI (Type 2 if group)	
Practice address	
City, state, ZIP	
Email	
Phone to schedule appointments	
Fax	

Additional practice locations q **Check if you will provide services at additional locations that bill using the same NPI as above, and complete the last page of this form (Additional Practice Locations).**

Billing address – Please set us know your remittance address.

q **Same as main practice location** q **Other (please enter below)**

Billing name	
Address	
City, state, ZIP	
Email	
Phone	
Fax	

Contract recipient – We send all contractual agreements by secure email from *Blue Cross <echosign@echosign.com>*. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

If we approve this application to join a Blue Cross group **contract, we must email your contract Attachment A *directly to you (the practitioner)* for signature. You are required to personally sign Attachment A to be legally bound to the practice's Agreement. Be sure to use an active email you check regularly.**

Practitioner's email (required) ______________________________

If you want someone to be copied when we email the practitioner, please provide their email

____

Welcome letter recipient – Before billing for services you provide to our members, you must register your practice with Payspan/EFT. Y**our welcome letter** will include information about how to register**.**

Let us know where to email your welcome letter (required) ______________________________

Contact person – Let us know the person to contact in case we have questions about this application.
***Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.**

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

Practitioner availability status

It is important that you notify us promptly when your practice status changes.

Are you available to see Blue Cross members full time and year-round? q **Yes** q **No**

If no, please explain ____

Are you:

q **Accepting new patients**

q **Not accepting new patients**

Will you offer telehealth? q **Yes** q **No**

q I understand that to serve Blue Cross Blue Shield members, I must be contracted with the local plan where my practice is physically located. (required)

Comments ____

Covering arrangements

Blue Cross agreements require that providers establish arrangements to render care as needed when they are unavailable.

❑ I attest that I have covering arrangements in place to ensure my patients have access to care when I am unavailable, in keeping with industry standards for my profession.

Blue Cross Product participation

If you are joining a group practice, we will enroll you in the same Products as the group. If you are a solo provider, make your Product selection in the Practice Application that follows.

Signature waiver

Please check one box. This waiver is legally binding.

q **I request a waiver of Blue Cross's requirement that all participating providers personally sign Blue Cross claim forms. This waiver will allow Blue Cross to accept claim forms submitted on my behalf that bear a facsimile signature or the printed words "signature waived" in lieu of my personal signature on the claim form.**

By requesting this waiver I acknowledge and undertake full personal responsibility for all claims submitted to Blue Cross on my behalf pursuant to this waiver as if I had personally signed each claim form.

I understand that claims will be submitted to Blue Cross only for services rendered by me to patients with whom I have an expressed or implied contract to render services for a fee and in accordance with the provisions of my Blue Cross provider agreement.

q **I decline a signature waiver and agree to personally sign every claim submission.**

Release and representations by the applicant

Please read the following statements. You must sign and date this section before sending your application.

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 other quality concerns.

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 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:

- **Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.**
- **I cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies me that my contract is in effect, at which time this application will become part of my contract.**
- **If Blue Cross accepts me for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.**
- **I must immediately send a *Contract 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 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 the applicant:

Signature ____

Print name ____

Date of signature ____

Send your completed, signed application as shown on page 1. Keep a copy for your files.

If we approve this contracting application, we will send an Attachment A for your signature.

Thank you for your interest in caring for our members.

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

Practice Application

Submit this section only once per practice if you are opening a new practice or changing your practice's tax ID number

If you want a new contract with Blue Cross and your practice…	Then…
• Bills for practitioners' services on a CMS-1500 or 837P using an Employer tax ID, and • Has not signed a Blue Cross group contract for your provider type, and • Has not already completed a Practice Application for the provider type and tax ID number entered below	• Complete this entire Practice Application. • Please send a form for each practice member. We cannot process your request for a contract without details on each practitioner.
• Is a solo practice	• **Complete this Practice Application except for the sections** called Contract recipient, **Practice** owners, and Practice **members.**

Your provider type (check one only):

q **Audiologists** q **Chiropractors** q **Licensed Dietitian Nutritionists** q **Optometrists**

Main practice location

Solo providers: If this address is your home, please be aware that it will be shown in our directory as a "practice" address.

q **Same as entered on page 2 for the practitioner** q **Other (please enter below)**

Practice name (legal name)	
DBA (as it appears on the W-9)	
Practice's tax ID number (same number as on the W-9)	
Practice's NPI that you bill under (Type 2 if group practice)	
Practice address	
City, state, ZIP	
Email	
Phone to schedule appointments	
Fax	

Contract recipient – We send all contractual agreements by secure email from *Blue Cross <echosign@echosign.com>*. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

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 practice, such as *owner, partner, president*.

Authorized signer's name	Business title	Email (required)

If you want someone to be copied when we email the authorized signer, please provide their email

____

Contact person – Let us know the person to contact in case we have questions about this application. *Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

Practice owner(s)

	Name
1	
2	
3	

Communications

By checking this box, I affirm that:

You must become a registered, active user of our secure website, bluecrossma.com/provider, to access the latest fee schedules, forms, policies, contractual notices, and other communications. You (or your practice) 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.

q **Our practice 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 Blue Cross members.

If we contract with you, your welcome letter will include instructions on how to register for Payspan/EFT.

q **Our practice agrees to comply with this requirement**

Welcome letters – Your practice's **welcome letter will include your Blue Cross Product participation and contract effective date.**

Each practitioner in your group will receive a separate welcome letter showing their effective date; this is when they may begin treating our members.

Let us know where to email your practice's welcome letter

Email **(required)** ____

Blue Cross Product participation

Please note: **All practitioners in the group must participate in the same Products.**

Check the Blue Cross Products you want to participate in:

q **All Products**

q **HMO** q **PPA/PPO** q **Indemnity** q **Medicare Advantage HMO** q **Medicare Advantage PPO**

For more information about the Products, look on bluecrossma.com/provider in Patient **Resources>Plans & Products>Product Overview.**

Practice members

How will new practice members be joined to your group contract?

- q **By signature of each practitioner**
- q **Through binding authority**
  (Consult your legal counsel to ensure your practice has full and complete authority to bind practitioners to the terms and conditions of your contract for all Blue Cross Products you have requested)

Send a form for each practitioner joining your practice. We cannot process your request for a contract without details on each practitioner.

If a practitioner is…	Then…
Already participating with Blue Cross	**Send a *Contract Update Form* in order to join them to your group agreement. The form is on Provider Central at Forms>Contract Updates.**
New to Blue Cross	**Send a *Contracting Application* after they have updated their CAQH profile at https://proview.caqh.org. Download applications from Provider Central at Office Resources>Enrollment>Contracting Applications.**

Release and representations by the practice

Please read the following statements. You must sign and date this section before sending 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 and group practice named above.

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 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:

- **Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.**
- **My group practice cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies us that our contract is in effect, at which time this application will become part of our contract.**
- **If Blue Cross accepts my practice for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.**
- **My practice must immediately send a *Contract 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 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 on behalf of the practice by:

Representative's signature		
Print name		
Business title		
Email	**(required)**	
Business name		
Date of signature		

Send your completed, signed application as shown on page 1. Keep a copy for your files.

Attach an IRS Form W-9 that is signed, dated, and completed with the name and Tax ID Number to which payments will be made. We cannot process your request without a W-9.

If we send you a new contract, please remember that only the authorized signer may sign.

*** 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.**

Additional Practice Locations for Appointments

Practitioner		NPI (Type 1)	
Practice name		**Practice NPI (Type 2)**	

Only locations where patients can make appointments to see you will be displayed in our provider directory, *Find a Doctor & Estimate Costs*.

We require a <u>complete</u> list of these locations, but please note that only five addresses *(including your Main practice location)* will be displayed in the directory.

For each address below, please check one box:

- **Appointments** – You see patients at this address, and they can make an appointment to see you here
- **Visits** – You see patients at this address but not by appointment *(listing these is not required)*
- **Covering** – You cover or fill-in at this address *(listing these is not required)*
- **Tests** – You read tests or perform imaging at this address *(listing these is not required)*

For the practice and NPI above, please list all additional locations *where patients can make appointments to see you.* How many copies of this page have you attached to the application? ☐

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

*Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Please notify us if the above information changes.

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.***