Print Clear form

MASSACHUSETTS

TECHNICAL DIAGNOSTIC IMAGING (TDI) APPLICATION

Complete this form and send it to BlueCrossNetworkContracting@bcbsma.com **or 617-246-6819**

Technical Component

Use this application if you would like to bill for the technical component of any diagnostic imaging modality.

- If you are applying only for the technical component of X-rays, ophthalmic A scans, or limited/follow-up obstetrical ultrasounds, submit the *Limited Technical Privileging Application*.
- Your organization must own, lease, or otherwise incur the full usage cost of diagnostic imaging equipment.

You must sign an agreement to bill for the services listed in this application.

Professional Component

Practitioners associated with your organization who would like to bill Blue Cross* for the interpretation of diagnostic imaging should submit the *Professional Privileging Application* if they are not already privileged by us. You must receive approval before billing for these services.

Ready to submit? Be sure to include the attachments

Send your completed, signed application with the following documents for your organization or practice. All documents must be current.

- A signed and dated IRS Form W-9 showing the name and Tax ID number to which payments will be made. We cannot process your request without a W-9. A form is attached.
- All documents required for your modality, as shown in the Service Site Information section.

Note: **Free-standing facilities** must have a unique NPI for each service site.
Professional practices are strongly encouraged to have a unique NPI for each practice location, as it may facilitate claims processing.

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 privileging 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 send the privileging decision to the email on the last page of this application.

The following information collected for privileging 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 sites are approved, 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).

Please check all that apply:

- ❑ You are not currently contracted with Blue Cross for the technical component of diagnostic imaging
- ❑ You are contracted for TDI and want to bill for the technical component of a new modality
- ❑ You are contracted for TDI and adding a service site
- ❑ You are contracted for TDI and changing diagnostic imaging equipment or technicians, etc.
- ❑ Other (please explain)

Organization information

Provider's legal name	
DBA (**as it appears on the W-9**)	
Type of organization	❑ Facility ❑ Professional practice
Tax ID Number (**same number as on the W-9**)	
National Provider Identifier (NPI)	
Blue Cross non-contracted provider number (if any)	
Medicare participating provider number	

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 or practice. The contract cannot be forward for signature.

The sender will be Blue Cross <echosign@echosign>. Add thi address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

Please list your authorized signatories, such as *owner, partner, president.*

Authorized signer's name	**Business title**	**Email** (required)

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

Product participation

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

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

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, 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.

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

❑ *Our organization agrees to comply with this requirement*

Welcome letter

Your welcome letter will also include your Blue Cross Product participation and contract effective date.

Let us know where to email your organization's welcome letter:

(required)

Service site information

Copy and complete pages 4 through 7 for <u>each location</u> where you would like to bill for the technical component. All sites submitted with this application must bill using the same Tax ID number.

By checking this box, I acknowledge that my organization must immediately submit a new application when there are changes to any of the service site information below. ❑

Service site **Site #** ____ **of** ____ **(total number of service sites)**

Please enter your primary site as Site #1

Site name		
Address		
City, state, zip		
Phone to schedule appointments/Fax		
NPI for this site		
Medicare participating # for this site		

Do you want this site listed as an Imaging Center in our provider directory? ❑ Yes ❑ No

Billing address

Same as… ❑ This site ❑ Main business location ❑ Management/parent company ❑ Other:

Billing company name		
Address 1		
Address 2		
City, state, zip		
Phone/Fax		

Accessibility

Does this site provide services or have a coverage arrangement:

24 hours a day, 7 days per week? ❑ Yes ❑ No Evenings? ❑ Yes ❑ No 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 office interpreter at this site?

Clinicians

Please list your on-site, supervising physicians.

Name	NPI (Type 1)

Please list each technologist on staff at this site.

Name	License or registration #	Modality

Please list the Blue Cross participating physicians who provide professional interpretation.

Any who are not privileged by Blue Cross should submit the *Professional Privileging Application.*

Name	NPI (Type 1)	Specialty

Imaging modalities

Enter the information **only** if your organization owns, leases, or otherwise incurs the full usage cost of the equipment at this site.

Imaging modality at this site	How many machines at this site	How many licensed technologists and practitioners perform technical component at this site	Required documents for this site
Angiography			Requirements depend upon the CPT codes you want to perform. Please enter the codes and we will contact you:
Bone densitometry			Registration from the Mass. DPH Radiation Control Program*
Breast ultrasound			Accreditation report from the American Institute of Ultrasound in Medicine (AIUM) or the American College of Radiology (ACR)
Cardiac CT scan			Accreditation report from the ACR or the IAC CT
CT scan			Accreditation report from the ACR or the IAC CT
Endovenous ablation therapy			*Free-standing facility or hospital only* Accreditation report from the IAC Vein Center
Fluoroscopy			**See list on the next page**
General ultrasound			Accreditation report from the AIUM or ACR
Magnetic resonance imaging (MRI)			Accreditation report from the IAC MRI or the ACR
Mammography			Accreditation, application or accreditation report from the ACR Mammography Program
Nuclear medicine (including nuclear cardiology and PET scans)			• Nuclear Regulatory Commission license and/or Registration from the Mass. DPH Radiation Control Program* • Medical Director's license and board certification
Ophthalmic B scans			No documents need to be submitted other than an IRS Form W-9, but you must sign a contract
Thyroid ultrasound (including diagnostic head and neck)			Diagnostic Head and Neck Ultrasounds for Evaluation of Thyroid and Parathyroid Disorders
Vascular ultrasound			Accreditation report from the IAC VT or ACR vascular laboratory accreditation
X-ray			**See list on the next page**

If applying only for X-ray, submit the *Limited Technical Privileging Application* instead.

Other Interventional – please list specific CPT codes:

* If the name on the registration is different than your organization's legal name on page 2, please attach a letter of explanation.

List of X-ray and Fluoroscopy documents required for this site

Write these two numbers on every document:
- Site # from the top of page 4
- Item # shown below

	Item #	
❑	**1**	Annual inspection reports for the current year (physicist report, such as FX Masse-Diagnostic X-Ray survey). If recommendations are noted on the survey, please provide a statement outlining how issue was addressed/resolved.
		Quality assurance/quality control plans specific to your facility, which should include descriptions of:
❑	**2**	How you minimize radiation exposure to patients, staff, and the public
❑	**3**	How you ensure the quality of diagnostic information
❑	**4**	How you use, store, and dispose of hazardous materials and equipment
❑	**5**	How you address medical and other emergencies
		Your safety hazard monitoring plan, which should include descriptions and/or copies of:
❑	**6**	Pregnancy questionnaire
❑	**7**	Infection control process
❑	**8**	Blood-borne pathogen exposure response
❑	**9**	Medical emergency response
❑	**10**	Radiation safety procedures and appropriate signage
❑	**11**	Shielding records
❑	**12**	Floor plan
❑	**13**	A copy of the credentials for your Radiation Safety Officer (RSO). Enter the name of your RSO below. The RSO is the on-site specialist who is responsible for overseeing the quality of radiation safety for the facility and personnel. For details about the credentials of an RSO, see Section 5 of the AAPM report: https://www.acr.org/-/media/ACR/Files/Radiology-Safety/Radiation-Safety/Radiation-Safety-Officer-Qualifications.pdf **Name**
❑	**14**	Equipment maintenance log for the past 12 months, if available; for a new office, please submit a sample form
❑	**15**	Procedures and policies for operating imaging equipment
❑	**16**	Documented process for retake rates that are measured and discussed quarterly
❑	**17**	Medical record reporting and retention policies and standards
❑	**18**	Record management and storage policies
❑	**19**	For fluoroscopy, certificate of attendance at fluoroscopy radiation safety training
❑	**20**	Radiologic Technologist License for personnel operating the equipment (technologist or practitioner)
❑	**21**	Current registration from the Mass. Department of Public Health's Radiation Control Program If the name on the registration is different than your organization's legal name on page 2, please attach a letter of explanation.

Additional requirements for certain modalities

By your signature below, your organization acknowledges and agrees to adhere to the following additional requirements as they apply to your modality.

- If we privilege your organization to perform CT scans:
  - it shall be subject to MGL c.111 s.5 M, N, O, and P
  - the medical director shall be a board certified radiologist, or radiation oncologist when used for treatment planning, with a minimum of six (6) months of documented full-time experience or instruction in CT, including physics, instrumentation, and clinical applications
  - all radiologic technologists must hold a current certificate of registration as a radiologic technologist from the American Registry of Radiology Technologists or be a graduate of a program approved by the Council on Medical Education, and be licensed in accordance with MGL c.111 s.5L and 105 CMR 125.000 et seq.
- If we privilege your organization to perform mammography:
  - all equipment must be specifically designed for mammography and meet the standards set forth at 105 CMR 127.017, 127.019. Your organization shall also comply with any additional regulations promulgated under MGL c.111N.
  - all radiologic technologists shall be licensed in accordance with MGL c.111 s.5L and 105 CMR 125.000 et seq., and have specialized training in mammography
  - your organization shall meet the additional record keeping requirements set forth at 21 CFR 900.12(c)(1)(iv) and 105 CMR 127.020
- If we privilege your organization to perform magnetic resonance imaging:
  - it shall comply with the requirements set forth at MGL c.111 s.5 M, N, O, and P. Your organization shall meet the Massachusetts Department of Public Health's "Interpretive Guidelines for Clinics Offering MRI Services" or, if operating under a Determination of Need (DoN) exemption, have a letter from the Massachusetts Department of Public Health's Radiation Control Program stating that your organization meets the Program's safety guidelines
  - the medical director shall be a board certified radiologist with a minimum of six (6) months of documented full-time experience or instruction in MRI, including physics, instrumentation, and clinical applications
  - all radiologic technologists must hold a current certificate of registration as a radiologic technologist from the American Registry of Radiology Technologists or be a graduate of a program approved by the Council on Medical Education and licensed in accordance with MGL c.111 s.5L and 105 CMR 125.000 et seq.
- If we privilege your organization to perform ultrasounds:
  - all ultrasound imaging equipment must be capable of providing high quality real time imaging, and be capable of producing the information that complies with the equipment and documentation requirements stated in the guidelines promulgated by the American Institute of Ultrasound in Medicine (AIUM) and the American Society of Echocardiography, or the American College of Radiology (ACR). All imaging equipment must be FDA-approved with acceptable and safe power output, and the appropriate frequency transducers shall be available for each examination. All imaging equipment should be kept up to date in order to be capable of state-of-the-art resolution.
  - sonographers must be registered with the American Registry of Diagnostic Medical Sonographers (ARDMS) or other nationally recognized professional organization of sonographers with prior approval of Blue Cross.
- If we privilege your organization to perform nuclear medicine:
  - it shall be licensed pursuant to MGL c.111 s.5L and 105 CMR 125.000 et seq.

Representations

Please read the following statements. You must sign and date this section.

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 privilege participating providers pursuant to various requirements, including, but not limited to, privileging 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 privileging 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, 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 a new TDI Application to Blue Cross when there are changes to any information in this application. For some changes, an *Update Form for Facilities* may be sufficient.
- 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	
Business name	
Email (required)	
Date	

Send your completed, signed application to BlueCrossNetworkContracting@bcbsma.com or 1-617-246-6819. 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 contract, please remember that only the authorized signer may sign.

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.*