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

Physician Assistants and Ancillary Advanced Practice Nurses:

Nurse Practitioners *Certified Nurse Midwives* *Certified Registered Nurse Anesthetists*

Contract Update Form

Questions? Write *ProviderApplicationStatus@bcbsma.com*.

Send completed form to *NetworkManagement@bcbsma.com* or fax to 1-617-246-4227.
If emailing, please include practitioner's *Last Name, First Name* in the Subject.

Use this form to notify Blue Cross* of a change to a contracted practitioner's practice status, etc. Keep a copy of this completed form for your files. If needed, you will receive a new contract for signature.

You cannot provide covered services and be reimbursed as a participating provider in any new practice or new Product until you are notified by Blue Cross that the new contract is in effect.

Check all that apply:	**And complete these sections:**
❑ Leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P	All sections except # 5, 10, 11, 12
❑ Staying with your current practice and joining a new practice	All except #3, 10, 11, 12
❑ Opening a practice	All except #3, 10, 11. Complete Group Practice Attachment
❑ Changing your practice's Tax ID number	1, 5, 12, 13, 14, Group Practice Attachment
❑ Want to add a Product to your Agreement	1, 2, 5, 13, 14, Group Practice Attachment
❑ Changing your Nurse Practitioner or Physician Assistant primary care or specialty care designation	1, 5, 6, 7, 8, 9, 10, 13
❑ Changing your practice availability	1, 5, 9, 13
❑ Changing your admitting privileges or hospital affiliation (not applicable to CRNAs)	1, 5, 6, 8, 13
❑ Changing your nurse practitioner certification	1, 5, 6, 7, 8, 9, 11, 13

Section 1. Individual practitioner information

Name _____

License number _____

National Provider Identifier (NPI Type 1) _____

Email (required) _____

Check your practice type:

❑ Certified Nurse Midwife ❑ Nurse Practitioner ❑ Physician Assistant

❑ CRNA

Section 2. Blue Cross Product participation

- To add a Product, please check **all** Products that you want to participate in.
- If you are joining a group practice, we will enroll you in the same Products as the group.

  A PA or NP whose practice is limited to pediatrics and/or neonatology may choose whether to participate in Medicare Advantage.
- If you are remaining as an independently practicing provider only, please check **all** Products in which you wish to participate:

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

* 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.

Section 3. Leaving a practice

By leaving a practice, you will also be leaving the Product participation associated with that practice. You must indicate in section 2 the Products in which you now wish to participate.

If you are leaving your primary contracted group, they will need to submit a termination in order to remove their group contract from your profile.

If leaving all Blue Cross practices, please submit the *Standardized Provider Information Change Form* instead.

Date leaving practice _____

Practice name _____

Practice's NPI (Type 2) _____

Practice location _____

City, state, ZIP _____

Phone ( ) _____

Section 4. Joining or opening a new practice

If your group has a new Tax ID and Type 2 NPI, please also complete the Group Practice Attachment on page 6.

Please verify with clinician and check one:

- ❑ This will be the clinician's new Primary practice
- ❑ This will be a Secondary practice affiliation

NPs and PAs only Your designation will determine how you are listed in our online provider directory. At this practice, will you provide (check one):

- ❑ Primary care services (NP/PA-primary care) - this means you render primary care but do not maintain a panel of patients
- ❑ Specialty care services (NP/PA-specialty care)

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

Employment or start date _____

Practice name _____

DBA (as reported to the IRS) _____

Practice's tax ID number _____

Practice's NPI (Type 2 if group) _____

Practice location* _____

City, state, ZIP _____

Phone to schedule appointments ( ) _____ Fax ( ) _____

Can patients contact the provider to make an appointment at this location using this phone number? ❑ Yes ❑ No

*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.

Additional locations ❑ Check if you provide services at additional locations, and complete the last page of this form.

Billing address ❑ Same as above ❑ Other:

Billing name _____

Address _____

City, state, ZIP _____

Email _____

Phone ( ) _____ Fax ( ) _____

Section 5. Existing Practice

Please verify with clinician and check one:
- ❑ This is the clinician's Primary practice
- ❑ This is a Secondary practice affiliation

Practice name _____

DBA (as reported to the IRS) _____

Practice's tax ID number _____

Practice's NPI (Type 2 if group) _____

Practice location* _____

City, state, ZIP _____

Email _____

Phone to schedule appointments ( ) _____ Fax: ( ) _____

Can patients contact the provider to make an appointment at this location using this phone number? ❑ Yes ❑ No

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

Additional locations ❑ Check if you provide services at additional locations, and complete the last page of this form.

Section 6. Nurse attestation regarding collaborative arrangement

To be completed by **NP**s and **CRNA**s:

- ❑ I comply with all requirements of the Mass. Board of Registration in Nursing as an Advanced Practice Nurse with **more** than two years of experience. (No need to submit collaborating physician or peer information).
- ❑ I comply with all requirements of the Mass. Board of Registration in Nursing as an Advanced Practice Nurse with **less** than two years of experience. My collaborating physician or peer information:

Name of physician or peer	**NPI Type 1**	**Hospital affiliation**

To be completed by **CNM**s:

- ❑ I confirm that I have a clinical relationship with an obstetrician/gynecologist.

Section 7. Covering arrangements

Blue Cross agreements require that providers maintain 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.

Section 8. Hospital affiliation and admitting privileges

You are:

❑ Changing your primary hospital affiliation ❑ Adding a secondary hospital affiliation

Name of hospital (required) _____

Initial date of appointment (MM/DD/YY) _____

Do you have admitting privileges at this hospital? ❑ Yes ❑ No

If you do not have admitting privileges at the above hospital, please tell us who arranges for your inpatient admissions. This arrangement will continue until you notify Blue Cross of a change.

Name of physician, practice, or hospitalist program

_____

List any secondary hospital affiliations that you want to appear with your name in our provider directory

_____

Section 9. Changing practitioner availability status

Check all locations where you wish to make changes.

At your ❑ Existing practice shown in section 5 ❑ New practice shown in section 4, you will be:

❑ Accepting new patients
❑ Not accepting new patients

Will you offer telehealth? ❑ Yes ❑ No

❑ 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: _____

Section 10. Changing your specialty designation

Check whether you will provide primary care services or specialty care services. This designation will determine how you are listed in our online directory.

❑ Primary care (adult medicine, family medicine, gerontology, internal medicine, pediatrics, and women's health)
Note: This means you will render primary care but **will not** maintain a panel of patients. This is **not** the same as a primary care provider. Your collaborating physician or peer must be contracted with Blue Cross as a primary care provider.

❑ Specialty care

Section 11. Changing your Nurse Practitioner certification

Indicate the new organization (AANP, ANCC, etc.) and attach a copy of your certificate _____

Section 12. New IRS Form W-9

A new W-9 is required to verify new billing information. If you are joining a contracted group, you do not need to attach a W-9.

❑ The attached IRS Form W-9 has been completed with the name and Tax ID number to which payments will be directed.

Section 13. Representations

❑ By checking this box, you hereby affirm and represent that all statements, answers, and information in this Contract Update Form are true and complete to the best of your knowledge and belief, and that you are duly authorized to provide information on behalf of the clinician named in section 1.

Name of person completing form _____

Business title _____

Company name _____

Email _____

Phone ( ) _____ Fax ( ) _____

Date _____

Section 14. Contract recipient

If we need to send you a new contract Attachment A, we must email it ***directly to you (the practitioner)*** for signature. You are required to personally sign a new 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) _____

You will receive a welcome letter showing the date you may begin treating our members at the new practice.

Email for welcome letter (required) _____

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Group Practice Attachment

Only complete this page if you are opening a new practice with a Type 2 NPI.

Practice Administration

If we need to send you 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.*

Name and business title _____

Email (required) _____

Please remember that only this person may sign the agreement we send you.

Practice owner(s)

_____

_____

_____

Practice Members

- Please list all ancillary advanced practice nurses and physician assistants in the group. Attach an additional sheet if needed.
- Each clinician who is **new to Blue Cross** must complete a Contracting Application. Download applications from Provider Central at Forms>Contracting Applications.
- Each clinician who is **currently participating with Blue Cross** must complete a separate Contract Update Form for Physician Assistants and Ancillary Advanced Practice Nurses. The form is on Provider Central at Forms>Contract Updates.
- These clinicians must be enrolled in the same Products as the group. However, if their specialty is limited to pediatrics or neonatology, they may choose whether to participate in Medicare Advantage.

Practitioner Name	Practice type (as in section 1)	NPI (Type 1)	Participate in Medicare Advantage? Y/N	Primary or Secondary with this group

Additional Practice Locations for Appointments

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

The above is your: ❑Existing practice ❑A practice you are joining or opening

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 the practice address you entered on page 2 or 3 of this form)* 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 Update Form?

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.*