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? Email *ProviderApplicationStatus@bcbsma.com* or call 1-800-316-2583.

Send completed form to *NetworkManagement@bcbsma.com* or fax 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. as listed below. Please retain a copy of this completed form for your files. If needed, a new contract will be mailed for you to complete and return.

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:	**Please complete sections:**
❑ You are 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
❑ You are staying with your current practice and joining a new practice	All sections except #3, 10, 11, 12
❑ You are opening a practice	All sections except #3, 10, 11. Do complete the Group Practice Attachment
❑ You are changing your practice's Tax ID number	1, 5, 12, 13, 14, Group Practice Attachment.
❑ You wish to add a Product to your Agreement	1, 2, 5, 13, 14, Group Practice Attachment
❑ You are a Nurse Practitioner or Physician Assistant changing your primary care or specialty care designation	1, 5, 6, 9, 10, 13
❑ You are changing your Collaborating/Supervising Physician	1, 5, 6, 7, 8, 13
❑ You are changing your practice availability	1, 5, 9, 13
❑ You are a CNM, NP, or PA changing your admitting privileges or hospital affiliation	1, 5, 8, 13
❑ You are an NP changing your certification	1, 5, 6, 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 administering anesthesia at a freestanding ambulatory surgery center

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, you must be enrolled in the same Products that the group and your collaborating or supervising physician participate in.

  For a PA or NP whose practice is limited to pediatrics and/or neonatology, enrollment in Medicare Advantage is optional.

- 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 NPI (Type 2): ______________________

Main practice location: ______________________

City, State, Zip code: ______________________

Phone: (   ) ______________________

Section 4. Joining or Opening a New Practice

In section 2, please indicate the Products you wish to participate in at this 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)

Employment or start date: ______________________

Practice name: ______________________

DBA (as reported to the IRS): ______________________

Practice Tax ID number: ______________________

Practice NPI (Type 2): ______________________

Main practice location: ______________________

City, State, Zip code: ______________________

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

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

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 code: ______________________

Email: ______________________

Phone: (   ) ______________________ Fax: (   ) ______________________

Section 5. Existing Practice

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

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 Tax ID number: ______________________

Practice NPI (Type 2): ______________________

Main practice location: ______________________

City, State, Zip code: ______________________

Email: ______________________

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

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

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

Section 6. Collaborating Arrangement *This section is required if you are joining or opening a practice.*

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 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 information is below.*

- The physician must be participating with Blue Cross in the same Products that you indicated in section 2.
- If you are an NP and your Collaborating Physician is an Emergency medicine physician, Radiologist, Anesthesiologist, or Pathologist (ERAP), they do not need to be credentialed by Blue Cross.
- NPs who render care in a psychiatric practice should use the Contract Update Form for Behavioral Health Professionals.

To be completed by **CNM**s:

❑ I have a clinical relationship with an OB/Gyn who is credentialed by and contracted with Blue Cross. The physician's information is below.*

*Name of physician	Specialty	NPI Type 1	Hospital affiliation

To be completed by **PA**s:

❑ I comply with all requirements of the Mass. Board of Registration in Nursing. (No need to submit supervising physician information)

Section 7. Covering Arrangement *This section is required if you are joining or opening a practice.*

Arranging for 24-hour coverage is a Blue Cross credentialing and contractual requirement. Please list the physicians and/or groups that provide coverage for you. Covering providers must be participating in the same Products that you requested in section 2.

Physician or Group Practice Name	NPI

Section 8. Changing Hospital Affiliation and Admitting Privileges

Your hospital affiliation must be a Blue Cross contracted acute care hospital and your admitting provider must be a Blue Cross credentialed and contracted physician or a hospitalist program.

❑ 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 indicate who arranges for your inpatient admissions and enter name(s) below. This arrangement will continue until you notify Blue Cross of a change.

❑ Your Collaborating or Supervising Physician
❑ Physicians in your practice
❑ Physicians not affiliated with your practice
❑ Hospitalist program

Name of physicians, practice, or hospitalist program checked:

____

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

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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. You must have a Collaborating/Supervising Physician who is listed with Blue Cross as a primary care physician.

❑ 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 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: ______________________________

Title: ______________________________

Business name: ______________________________

Email: ______________________________

Phone: ( ) ______________________________ Fax: ( ) ______________________________

Date: ______________________________

Section 14. Contract Recipient

Each practitioner is 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): ______________________________

MASSACHUSETTS

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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

Please list those who are authorized to sign contracts on behalf of the practice, such as Owner, Partner, President.

Name and title	Email (required)

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 **not currently participating with Blue Cross** must complete a Contracting Application. You can download the application at bluecrossma.com/provider. Under Forms, click Forms Library > 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. Go to bluecrossma.com/provider. Under Forms, click Forms Library > Contract Update Forms.
- 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

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

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

For the practice and NPI above, we require a complete list of locations where you will or do provide services.

How many copies of this page have you attached? ____

Please note that only five locations (*including your primary practice location*) will be displayed in our provider directory, *Find a Doctor & Estimate Costs*. Only locations where patients can make appointments to see you will be displayed.

For each address, 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
- **Covering** – You cover or fill-in at this address
- **Tests** – You read tests or perform imaging at this address

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.*