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

Behavioral Health Professionals

Contract Update Form

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

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.

Use this form to notify Blue Cross* of a change to a contracted practitioner's practice status, etc. as listed below. S^^] aÁ&[ ] ˆÁ- this completed form for your files. If needed, ˆ[˘ Á ã|Á^&^ã¢^Áa 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 please complete these sections:
☐ Šeaving your current practice and joining a newÁ¦æ&cã&^Á©æ will bill for your services on a CMS-1500 or 837P	All sections except #5, 9, 10 Complete the Behavioral Health Clinical Profile
☐ Ùtaying with your current practice and joining a ne¸ Á¦æ&cã&^	All sections except #2, 3, 9, 10 Complete the Behavioral Health Clinical Profile
☐ Upening a practice	All sections except #3, 9. Complete the Group Practice Attachment and Behavioral Health Clinical Profile
☐ Ôhanging your practice's Tax ID number	1, 5, 10, 11, 12, Group Practice Attachment
☐ Yæ) cto add a network (Product) to your Agreement	1, 2, 5, 11, 12 Nurses: also complete section #6
☐ Ô@anging your practice availability	1, 5, 8, 11, Behavioral Health Clinical Profile
☐ You are a psychiatrist updating your specialty	1, 5, 9, 11, Behavioral Health Clinical Profile
☐ You are a nurse changing your collaborating physician	1, 5, 6, 11, Behavioral Health Clinical Profile
☐ You are a psychiatric nurse practitioner (PNP) changing your certification	1, 5, 11, Behavioral Health Clinical Profile

Section 1. Individual dractitioner]nformation

Name ______________________________

Specialty ______________________________

License number ______________________________

National Provider Identifier (NPI Type 1) ______________________________

Email (required) ______________________________

Section 2. Blue Cross Product darticipation

- 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.
- If you are remaining as an independently practicing provider only, please check **all** Products that you want to participate in.

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

*Medicare Advantage is optional for Child Psychiatrists.

* 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 network (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 of this form.

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 5.

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

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

❑ If you are exclusively practicing at your Massachusetts residence, and do not want your street address displayed in our provider directory, please check this box and our directory will display *"Call for Appointment."* Your city and zip code will display.

❑ 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)

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 practice locations ❑ Check this box if you provide services at additional locations, and complete the last page of this form (before the BH Clinical Profile).

Billing address ❑ Same as above ❑ Other:

Billing name ______________________________

Address ______________________________

City, state, ZIP ______________________________

Email ______________________________

Phone (   ) ______________________ Fax (   ) ______________________

Clinical Profile

If you are leaving a group and starting an independent practice, please complete the attached Clinical Profile so that your correct practice information appears in our provider directory.

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© ax ID number ______________________________
Practice© NPI (Type 2 [illegible]) ______________________________
Úractice locationE ______________________________
City, •tate, ZOÚ ______________________________
Email ______________________________
Phone to schedule appointments ( ) ______________________________ Fax ( ) ______________________________

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

[illegible]

Additional locations ☐ Check if you provide services at additional locations, and complete the last page of this form (before the BH Clinical Profile).

Section 6. Nurse Uttestation fegarding Wollaboratij Y Urrangement

☐ Advanced Practice Nurse with **more** than two years of experience: I comply with all requirements of the Mass. Board of Registration in Nursing. (No need to submit collaborating physician information)

☐ Advanced Practice Nurse with **less** than two years of experience: I comply with all requirements of the Mass. Board of Registration in Nursing. My collaborating physician or peer information is as follows:

BUa Y cZdsychiatrist cf dYYf	**NPI**

Section 7. Covering Urrangementg

Blue Cross [illegible]

☐ [illegible]

Section 8. Changing dractitioner availability status

For all your locations, please indicate the type of visits you provide (within Massachusetts only):

- ☐ In-person visits
- ☐ Telehealth (If you offer Telehealth exclusively, our provider directory will display "*Call For Appointment*" in place of your street address)
  - ☐ 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: ______________________________

Check all locations where you wish to make changes.

At your ☐ existing practice shown in section 5 ☐ new practice show in section 4, you will be:

- ☐ Accepting new patients
- ☐ Not accepting new patients

Section 9. Updating specialty or board certification status *For psychiatrists*

This information will be shown on your *Find a Doctor* profile in our provider directory.

Primary specialty: ______________________________ Board certified? ☐ Yes ☐ No

Please list all additional specialties:

______________________________ Board certified? ☐ Yes ☐ No

______________________________ Board certified? ☐ Yes ☐ No

______________________________ Board certified? ☐ Yes ☐ No

Section 10. 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 11. Representations

☐ By checking this box, you hereby affirm and represent that all statements, answers, and information included 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 practitioner named in section 1.

Name of person completing form ______________________________

Business title ______________________________

Company name ______________________________

Email ______________________________

Phone ( ) ______________________________ Fax ( ) ______________________________

Date ______________________________

Section 12. 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) ______________________________

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 the 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 clinicians in the practice. Attach an additional sheet if needed.
- Each clinician who is **new to Blue Cross** must also complete a Blue Cross Contracting Application. You can download applications at bluecrossma.com/provider. In Office Resources, click Enrollment > Contracting Applications.
- Each clinician who is **currently participating with Blue Cross** must complete a Contract Update Form for Behavioral Health Professionals, available on bluecrossma.com/provider at Forms>Contract Updates.
- Medicare Advantage is optional for Child Psychiatrists.

Clinician Name	Licensure type	NPI (Type 1)	Child Psych 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 complete 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.

MASSACHUSETTS

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Behavioral Health Clinical Profile

Information from this Clinical Profile will be made available to members to aid them in accessing appropriate care.

Provider's name: ______________________________

Provider's NPI: ______________________________

Client Information

Check the age ranges of the client populations to which you offer services:

q Older adults (65 and over)
q Younger children (0 to 4)
q Older children (5 to 11)
q Adolescents (12 to 17)
q Adults (18 to 64)

List any languages (including sign language) other than English that you speak fluently and in which you can provide treatment:

____

Areas of Expertise

Check all that pertain to the types of treatments you provide:

q Behavioral therapy
q Couples therapy
q Cognitive behavioral therapy
q Dialectical behavioral therapy
q Family therapy
q Group therapy
q Individual therapy
q Neuropsychological testing
q Outpatient medical detox services
q Psychological testing
q Psychopharmacology

Please check all that pertain to the types of disorders you treat:

q Adjustment disorders
q Anxiety disorders
q Attention deficit disorders
q Autism spectrum disorders
q Chronic mental disorders
q Conduct disorders
q Depressive disorders
q Developmental disorders
q Eating disorders
q Obsessive compulsive disorders
q Organic mental disorders
q Personality disorders
q Sexual dysfunctions
q Substance use

Please check all that pertain to the types of subspecialties you treat:

q ACOA/Co-dependency
q Adoption
q AIDS/HIV
q Chronic medical illness
q Chronic pain
q Gambling addictions
q Gay/lesbian
q Grief counseling
q Health care professionals
q Hearing impaired
q Homebound patients
q Internet addictions
q Law enforcement professionals
q Military professionals/family
q New immigrants
q Nursing home patients
q PTSD
q Physical abuse
q Physical disabilities
q Sexual abuse
q Sexual addictions
q Trauma

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.*