



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](mailto:ProviderApplicationStatus@bcbsma.com) or call 1-800-316-2583.

Send completed form to [BlueCrossContractOps@bcbsma.com](mailto: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. 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:

- You are leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P
- You are staying with your current practice and joining a new practice
- You are opening a practice
- You are changing your practice's Tax ID number
- You wish to add a network (Product) to your Agreement
- You are changing your practice availability
- You are a psychiatrist updating your specialty
- You are a nurse changing your collaborating physician
- You are a psychiatric nurse practitioner (PNP) changing your certification

### And please complete these sections:

- All sections except #5, 9, 10  
Complete the Behavioral Health Clinical Profile
- All sections except #2, 3, 9, 10  
Complete the Behavioral Health Clinical Profile
- All sections except #3, 9. Complete the Group Practice Attachment and Behavioral Health Clinical Profile  
1, 5, 10, 11, 12, Group Practice Attachment
- 1, 2, 5, 11, 12 **Nurses: also complete section #6**
- 1, 5, 8, 11, Behavioral Health Clinical Profile
- 1, 5, 9, 11, Behavioral Health Clinical Profile
- 1, 5, 6, 11, Behavioral Health Clinical Profile
- 1, 5, 11, Behavioral Health Clinical Profile

## Section 1. Individual Practitioner Information

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_

License number: \_\_\_\_\_

National Provider Identifier (NPI Type 1): \_\_\_\_\_

Email: **(required)** \_\_\_\_\_

## 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 participates in.
- 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 not applicable to LADCs-I, LMFTs, or LMHCs and 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 NPI (Type 2): \_\_\_\_\_  
Main practice location: \_\_\_\_\_  
City, State, Zip code: \_\_\_\_\_  
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 (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

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 practice 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: ( ) \_\_\_\_\_

### 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**

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

**Section 6. Collaborating Arrangement**

*This section may be required if you are a nurse joining a practice or changing your collaborating physician.*

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 as follows:

<b>Psychiatrist's Name</b>	<b>NPI</b>
_____	_____
_____	_____

Each collaborating ("supervising") physician listed above must be board certified or board eligible in psychiatry.

**Section 7. Covering Arrangement**

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

<b>Clinician or Group Practice</b>	<b>NPI</b>
_____	_____
_____	_____
_____	_____

## Section 8. Changing Practitioner Availability Status

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

In-person visits

Telehealth

For Telehealth only, the 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 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: \_\_\_\_\_

Title: \_\_\_\_\_

Business name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Date: \_\_\_\_\_

## Section 12. 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 to receive the 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

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 clinicians in the practice. Attach an additional sheet if needed.
- § Each clinician who is **not currently participating with Blue Cross** must also complete a Blue Cross Contracting Application. You can download the application at [bluecrossma.com/provider](http://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. Log onto [bluecrossma.com/provider](http://bluecrossma.com/provider). In Office Resources, click Enrollment > Maintaining & Changing Status.
- § LADCs-I, LMHCs, LMFTs, and Child Psychiatrists are exempt from participation in Medicare Advantage.

Clinician Name	Licensure type	NPI (Type 1)	n/a	Primary or Secondary with this group
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____



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:

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

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:

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

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

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

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

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

## 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)	<input type="checkbox"/> Appointments*	<input type="checkbox"/> Visits*	<input type="checkbox"/> Covering <input type="checkbox"/> Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	
Check one (required)	<input type="checkbox"/> Appointments*	<input type="checkbox"/> Visits*	<input type="checkbox"/> Covering <input type="checkbox"/> Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	
Check one (required)	<input type="checkbox"/> Appointments*	<input type="checkbox"/> Visits*	<input type="checkbox"/> Covering <input type="checkbox"/> Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	
Check one (required)	<input type="checkbox"/> Appointments*	<input type="checkbox"/> Visits*	<input type="checkbox"/> Covering <input type="checkbox"/> Tests

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	
Check one (required)	<input type="checkbox"/> Appointments*	<input type="checkbox"/> Visits*	<input type="checkbox"/> Covering <input type="checkbox"/> 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.**

# Request for Taxpayer Identification Number and Certification

Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Give Form to the  
 requester. Do not  
 send to the IRS.

<b>Print or type.</b> <b>See Specific Instructions on page 3.</b>	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. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> 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. <input type="checkbox"/> 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) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	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)	

<b>Part I</b>	<b>Taxpayer Identification Number (TIN)</b>																									
	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 <i>How to get a TIN</i> , later.	Social security number <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">-</td> <td colspan="3" style="text-align: center;">-</td> <td colspan="6"></td> </tr> </table>													-			-								
-			-																							
	Note: If the account is in more than one name, see the instructions for line 1. Also see <i>What Name and Number To Give the Requester</i> for guidelines on whose number to enter.	or Employer identification number <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">-</td> <td colspan="9"></td> </tr> </table>													-											
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<b>Part II</b>	<b>Certification</b>		
	Under penalties of perjury, I certify that: <ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>I am a U.S. citizen or other U.S. person (defined below); and</li> <li>The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.</li> </ol> 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.		
<b>Sign Here</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border-bottom: 1px solid black;">Signature of U.S. person</td> <td style="width: 40%; border-bottom: 1px solid black;">Date</td> </tr> </table>	Signature of U.S. person	Date
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](http://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.*