MASSACHUSETTS

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

Opioid Treatment Program Application

Send completed form with the requested documentation to *BlueCrossNetworkContracting@bcbsma.com* or fax 617-246-6819.

Please review the global and provider type credentialing requirements at www.bluecrossma.com/provider. Do not apply unless you meet these requirements.

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 credentialing 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 notify you of the credentialing decision within 60 days, using the main business address on page 2.

The following information collected for credentialing 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 we approve this application, we will send an agreement for your signature. You may contact us abut the status of your participation at providerapplicationstatus@bcbsma.com or 1-800-316-BLUE (2583).

Supporting documentation

Fax your completed, signed application to 617-246-6819 with the following documents as they relate to your organization (and for each site, if different). All documents must be current.

Note: If your license has expired, a Chapter 30A letter from the Massachusetts Department of Public Health (DPH) is required.

- A signed and dated IRS Form W-9 showing the name and Tax ID number to which payments should be directed. A blank form is attached for your convenience.
- Accreditation certificate from one of the following:
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Council on Accreditation (COA)
  - The Joint Commission (TJC)
- Certifications from all of the following:
  - Substance Abuse and Mental Health Service Administration (SAMHSA)
  - DEA certificate
  - Massachusetts Controlled Substances Registration (MCSR)
- DPH Bureau of Substance Abuse Services Clinic License
- Medical director's board certification and license

* 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.

Organization information

Provider's legal name

DBA (**as it appears on the W-9**)

Tax ID number

National Provider Identifier (NPI type 2)

Blue Cross non-contracted provider number (if any)

Do you participate in Medicare?

- ❑ Yes – enter current Medicare participating provider number
  - – and enter effective date of participation
- ❑ Pending – enter date you applied for Medicare participation
- ❑ No

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 signatories

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, such as *owner, partner, president*. **It cannot be forwarded for signature.**

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

Name of authorized signer	**Title**	**Email** Required

If you would like anyone cc'd for review, please provide their email

Product participation

Check the 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, http://www.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.

❑ *Our organization agrees to comply with this requirement*

Where should we email instructions on how to register for Payspan? _____

License and malpractice history

In the following questions, "you" and "your" refer to the applicant organization/facility/program and its officers, partners, medical directors, and other principals. For each "yes" answer, please attach a detailed explanation.

1	Have any judgments been awarded against you or settlements made by you or on your behalf?	❑Yes	❑No
2	Has your license to practice ever been denied, limited, suspended, or revoked, or otherwise subject to any conditions in any jurisdiction?	❑Yes	❑No
3	Have you ever been disciplined, suspended, or terminated by any government or private third-party payer (for example, Medicare or MassHealth)?	❑Yes	❑No
4	Are any formal disciplinary charges pending, against you or your clinical employees, before any licensing authority in Massachusetts or elsewhere?	❑Yes	❑No
5	Have you ever pled guilty to or been convicted of a felony?	❑Yes	❑No
6	Have you ever been the subject of any Blue Cross Blue Shield, Medicare, MassHealth/Medicaid, or any other medical reimbursement plan suspension or probation proceedings, or ever been restricted from receiving payments from any Blue Cross Blue Shield, Medicare, Medicaid (any state), or other third-party program?	❑Yes	❑No
7	Have you had a participating provider application rejected by any HMO, PPO, or other prepaid health care plan?	❑Yes	❑No
8	Have you ever had a participating provider contract terminated by any HMO, PPO, or other prepaid health care plan?	❑Yes	❑No

Service site information

Copy and complete pages 4 and 5 for <u>every</u> licensed location where you would like to provide services.

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

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

Site name	
Address	
City or town, state, zip	
Phone to schedule appointments/Fax	
NPI for this service site, if different	

Billing address

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

Billing company name	
Address 1	
Address 2	
City or town, state, zip	
Phone/fax	

Accessibility

Does this site accept new patients: Outside of normal business hours (M-F, 8-5)? ❑ Yes ❑ No
Evenings? ❑ Yes ❑ No Weekends? ❑ Yes ❑ No

Does this site provide services: Outside of normal business hours (M-F, 8-5)? ❑ Yes ❑ No
Evenings? ❑ Yes ❑ No Weekends? ❑ Yes ❑ No

Does this site have coverage: 24 hours a day, 7 days per week? ❑ Yes ❑ No
Evenings? ❑ Yes ❑ No Weekends? ❑ Yes ❑ No

Is this site prepared to continue dispensing medications during severe weather conditions, such as blizzards?
❑ 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 an office interpreter at this site?

License for this site

License number

Check if the number entered and license attached for Site #1 applies to all sites ❑

Check if you attached a copy of your current license issued by the Mass. DPH Bureau of Substance Abuse Services Clinic ❑

If your license has expired, check if you attached a copy of your Chapter 30A letter from the Massachusetts DPH ❑

2nd page for **Site #** ☐

Medical director for this site

Check if the medical director information entered for Site #1 applies to all sites ☐

Your medical director must:

- have a current, valid, and unrestricted Massachusetts medical license
- specialize in Addiction Medicine or Addiction Psychiatry
- be credentialed by Blue Cross even if he/she is not providing direct patient care.

Name	
NPI	
License number	

Check if you attached copies of the medical director's license and board certification in addiction psychiatry and/or American Board of Addiction Medicine certification ☐

Accreditation for this site

Check if the accreditation information entered and certificate attached for Site #1 applies to all sites ☐

Please indicate your accreditation:

Commission on Accreditation of Rehabilitation Facilities (CARF)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

Council on Accreditation (COA)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

The Joint Commission (TJC)

Date of accreditation

Term of accreditation: From To

If pending, date you will receive full accreditation

Check if you attached certificate(s) for the accreditation indicated above ☐

Certifications for this site

Check if you attached copies of each certificate:

Substance Abuse and Mental Health Service Administration (SAMHSA) ☐

Current and valid DEA certificate ☐

Massachusetts Controlled Substances Registration (MCSR) ☐

Insurance information for this site

Check if insurance information entered for Site #1 applies to all sites ☐

Present malpractice carrier

Name

Present liability carrier

Name

Representations

Please read the following statements. You must sign and date this section before submitting your application for a new contract.

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 re/credential participating providers pursuant to various requirements, including, but not limited to, credentialing 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 credentialing 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, the provider's malpractice carriers, the National Practitioner Data Bank, 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 an *Update Form* to Blue Cross when there are changes to any information in this application.
- 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	
Company name	
Email Required	
Date	

If we send you a contract, please remember that only the authorized persons you have identified 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.*