



# CNPPCP and PAPCP Contracting Application

Questions? Read our [Contracting Q & As](#).

Complete this form online. Leaving blanks will delay processing.

**Fax completed form to 617-246-4227**

Blue Cross\* will evaluate this application according to your 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.

**Please do not apply unless you meet the global and provider type credentialing requirements.**

The requirements can be viewed at [bluecrossma.com/provider](http://bluecrossma.com/provider) in [Office Resources](#)>[Enrollment](#)>[Credentialing & Recredentialing](#)>[Credentialing](#).

Each practitioner must **complete the online application** through the Council for Affordable Quality Healthcare (CAQH) website at <https://proview.caqh.org>.

If...	Then...
You're already a CAQH provider	<ul style="list-style-type: none"> <li>Update all information (including expired documents).</li> <li>Choose the option to authorize all healthcare organizations. This will allow us to access your information.</li> </ul>
You're not a CAQH provider	<ul style="list-style-type: none"> <li>Log onto the CAQH website and self-register.</li> <li>Once registered, thoroughly complete your <i>Integrated Massachusetts Application</i> and submit all required documents.</li> </ul>
You're not sure of your status	Call CAQH at 1-888-599-1771.

## Please check one:

### I am joining a group practice

- I am new to Blue Cross and joining a practice or facility that submits claims on a CMS-1500 or 837P

### I am contracting as a solo provider

- I bill under a social security number or an Employer tax ID (EIN) as a sole proprietor, AND
- I do not currently reimburse any practitioners for services.

## Ready to send your application?

Be sure to attach a copy of your current certificate.

## If you want a new contract for your [group or solo practice](#), you must also attach:

- A completed Practice Application (beginning on page 8)
- An IRS Form W-9 that is signed, dated, and completed with the name and Employer tax ID (EIN) to which payments will be made. **We cannot process your request without a W-9.** A form is attached.

### Practitioner information

Your provider type (check one only):

Certified Nurse Practitioner-Primary Care Provider (CNPPCP)

Physician Assistant-Primary Care Provider (PAPCP)

**If you don't have a current and valid Federal Drug Enforcement Agency (DEA) number, please stop here.** You may still apply for participation as a certified nurse practitioner or physician assistant, but you must have a DEA number to be a CNPPCP or PAPCP.

First name	
Last name	
National Provider Identifier (NPI Type 1)	
Social security number	
Date of birth	
Massachusetts license number	
Federal Drug Enforcement Agency (DEA) certificate #	

### Practice location information

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.

Employment or start date at this practice (month/day/year) \_\_\_\_\_

***You may only be contracted as a primary care provider with a patient panel under a single NPI.***

#### Main practice location

Practice name (legal name)	
DBA (if reported to the IRS)	
Practice's tax ID number	
Practice's NPI (Type 2 if group)	
Practice address	
City, state, ZIP	
Email	
Phone to schedule appointments	
Fax	

**Additional practice locations** – If you will provide services at additional sites that bill using the same NPI as above, please complete this table.

	Site name	Street address	City, state, ZIP	Phone to schedule appointments
1				
2				

**Billing address** – Please give us your pay-to address.

Same as main practice location       Other (please enter below)

Billing name	
Address	
City, state, ZIP	
Email	
Phone	
Fax	

**Contract recipient** – As part of our efforts to improve the contracting process, we use electronic signature. The sender will be Adobe Sign <echosign@echosign.com>. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

If we approve this application to join a Blue Cross contract, we must email your contract Attachment A **directly to you (the practitioner)** for signature.

Practitioner's email (required) \_\_\_\_\_

If you want someone to be copied when we email the practitioner, please provide their email

\_\_\_\_\_

**Welcome letter recipient** – If we contract with you, you may not begin treating our members until you receive your welcome letter showing the effective date of your participation in the practice's Blue Cross contract.

Let us know where to email your welcome letter (required) \_\_\_\_\_

**Contact person** – Let us know the person to contact in case we have questions about this application.

*Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

## Practitioner availability status and services

It is important that you notify us promptly when your practice status changes.

Are you:

Accepting new patients\*

\*Please note: Your agreement requires you to accept any Blue Cross member assigned to your Plan Panel.

Do you offer telehealth/telemedicine (video visits)?  Yes  No

Do you provide lactation counseling services?  Yes  No

## Physician Assistant-Primary Care Providers only

Please attach a copy of your certificate, or **we will not be able to process this application.**

National Commission on Certification of Physician Assistants certificate # \_\_\_\_\_

Check your specialty:

Family Medicine

Internal Medicine

Pediatrics

## Certified Nurse Practitioner-Primary Care Providers only

*Note:* We use the term "Nurse Practitioner-Primary Care Provider" (NP-PCP) in our contracts and communications.

Please attach a copy of your certificate, or **we will not be able to process this application.**

Under your specialty, check the organization that certifies you:

### Family Medicine

American Nurses Credentialing Center (ANCC)—adult, family medicine

American Academy of Nurse Practitioners Certification Board (AANPCB)—adult, family medicine

National Certification Corporation for Obstetric, Gynecological and Neonatal Nursing Specialties (NCC)—women's health. *Please note:* Your collaborating physician must be a Blue Cross credentialed family medicine physician.

### Internal Medicine

American Nurses Credentialing Center (ANCC)—adult, geriatrics

American Academy of Nurse Practitioners Certification Board (AANPCB)—adult, geriatrics

National Certification Corporation for Obstetric, Gynecological and Neonatal Nursing Specialties (NCC)—women's health. *Please note:* Your collaborating physician must be a Blue Cross credentialed internal medicine physician.

### Pediatrics

American Nurses Credentialing Center (ANCC)

Pediatric Nursing Certification Board (PNCB)

**Collaborating/supervising arrangement (to be completed by all practitioners)**

Your collaborating/supervising physician must be credentialed by and contracted with Blue Cross.

**List your collaborating/supervising physician(s)**

	<b>Name of physician</b>	<b>Specialty</b>	<b>NPI Type 1</b>	<b>Hospital affiliation</b>
1				
2				

NPPCPs:  By checking this box, I attest that I have signed mutually agreed-upon, written practice guidelines with the collaborating physician(s) named above.

PAPCPs: You and your supervising physician(s) must render care to the same clinical population.

**Covering arrangement**

Arranging for 24-hour coverage, and coverage when you are ill or on vacation, is a Blue Cross contractual requirement. Your covering providers must be participating in the same Blue Cross Products as your practice. Tell us which Blue Cross-credentialed physicians or groups will provide coverage for you:

Members of my group practice who are credentialed by Blue Cross  Other (please enter below)

	<b>Name of physician or other group practice</b>	<b>NPI</b>
1		
2		
3		

**Hospital affiliation and admitting privileges**

Your primary acute care hospital, if any \_\_\_\_\_

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 and enter their name(s) below. This arrangement will continue until you notify us of a change.

- My collaborating or supervising physician
- Physicians in the practice I am joining
- Physicians not affiliated with the practice I am joining
- Hospitalist program

Name of physician, practice, or hospitalist program checked

\_\_\_\_\_

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

\_\_\_\_\_

## Blue Cross Product participation

If you are joining a group practice, we will enroll you in the same Products as the group.

Your Blue Cross provider agreement requires all practice members to participate in the same Products, with limited exceptions. For example, if your specialty is limited to pediatrics, you may choose whether to participate in our Medicare Advantage Product.

Check this box if you do **not** want to participate in Medicare Advantage

If you are a solo provider, make your Product selection in the Practice Application that follows.

## Signature waiver

**Please check one box. This waiver is legally binding.**

I request a waiver of Blue Cross's requirement that all participating providers personally sign Blue Cross claim forms. This waiver will allow Blue Cross to accept claim forms submitted on my behalf that bear a facsimile signature or the printed words "signature waived" in lieu of my personal signature on the claim form.

By requesting this waiver I acknowledge and undertake full personal responsibility for all claims submitted to Blue Cross on my behalf pursuant to this waiver as if I had personally signed each claim form.

I understand that claims will be submitted to Blue Cross only for services rendered by me to patients with whom I have an expressed or implied contract to render services for a fee and in accordance with the provisions of my Blue Cross provider agreement.

I decline a signature waiver and agree to personally sign every claim submission.

## Release and representations by the applicant

**Please read the following statements. You must sign and date this section before sending your application.**

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 other quality concerns.

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 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:

- Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.
- I cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies me that my contract is in effect, at which time this application will become part of my contract.
- If Blue Cross accepts me for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.
- I must immediately send a *Contract 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 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 the applicant:**

Signature \_\_\_\_\_

Print name \_\_\_\_\_

Date of signature \_\_\_\_\_

**Fax your completed, signed application to 1-617-246-4227. Keep a copy for your files.**

**If we approve this contracting application, we will send an Attachment A for your signature.**

Thank you for your interest in caring for our members.



# Practice Application

Submit this section only once per practice if you are opening a new practice or changing your practice's tax ID number

If you want a new contract with Blue Cross and your practice...	Then...
<ul style="list-style-type: none"> <li>Bills for practitioners' services on a CMS-1500 or 837P using an Employer tax ID, and</li> <li>Has not signed a Blue Cross group contract for your provider type, and</li> <li>Has not already completed a Practice Application for the provider type and tax ID number indicated below</li> </ul>	<ul style="list-style-type: none"> <li>Complete this entire Practice Application.</li> <li>Please send a form for each practice member. We cannot process your request for a contract without details on each practitioner.</li> </ul>
<ul style="list-style-type: none"> <li>Is a solo practice</li> </ul>	<ul style="list-style-type: none"> <li>Complete this Practice Application except for the sections on Practice members, Practice owners, and Contract recipient.</li> </ul>

Your provider type (check one only):

- Certified Nurse Practitioner-Primary Care Providers
- Physician Assistant-Primary Care Providers

**Main practice location**

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

- Same as entered on page 2 for the practitioner
- Other (please enter below)

Practice name (legal name)	
DBA (as it appears on the W-9)	
Practice's tax ID number (same number as on the W-9)	
Practice's NPI that you bill under (Type 2 if group practice)	
Practice address	
City, state, ZIP	
Email	
Phone to schedule appointments	
Fax	



**Additional practice locations** – If you will provide services at additional sites that bill using the same NPI as above, please complete this table.

	Site name	Street address	City, state, ZIP	Phone to schedule appointments
1				
2				
3				
4				

**Contract recipient** – As part of our efforts to improve the contracting process, we use electronic signature. The sender will be Adobe Sign <echosign@echosign.com>. Add this address as a trusted sender, and check your spam or junk mail folders to make sure you are receiving our email.

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 practice, such as *owner, partner, president*.

Authorized signer's name	Business title	Email (required)

If you want someone to be copied when we email the authorized signer, please provide their email

\_\_\_\_\_

**Contact person** – Let us know the person to contact in case we have questions about this application. *Please note:* If we are unable to process your request due to missing information, we will notify this person via fax or email.

Name and business title	
Company name	
Email (required)	
Phone	
Fax	

**Please list the practice owner(s)**

	Name
1	
2	
3	

## Communications

You must become a registered, active user of our secure website, [bluecrossma.com/provider](http://bluecrossma.com/provider), to access the latest fee schedules, forms, policies, contractual notices, and other communications. You (or your practice) will need to keep your email 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.

**By checking this box, I affirm that:**

- Our practice 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 Blue Cross members.

If we contract with your, your welcome letter will include instructions on how to register for Payspan/EFT.

- Our practice agrees to comply with this requirement

**Welcome letters** – Your welcome letter will also include your Blue Cross Product participation and contract effective date.

Each practitioner in your group will receive a separate welcome letter showing their effective date; this is when they may begin treating our members.

Let us know where to email your practice's welcome letter

Email (required) \_\_\_\_\_

## Blue Cross Product participation

*Please note:* All practitioners in the group must participate in the same Products.

Please check the Products you want to participate in:

**All Products**

HMO     PPA/PPO     Indemnity     Medicare Advantage HMO     Medicare Advantage PPO

For more information about the Products, look on [bluecrossma.com/provider](http://bluecrossma.com/provider) in [Office Resources>Plans & Products>Product Overview](#).

## Practice members

How will new practice members be joined to your group contract?

By signature of each practitioner

Through binding authority

*(Consult your legal counsel to ensure your practice has full and complete authority to bind practitioners to the terms and conditions of your contract for all Blue Cross Products you have requested)*

Send a form for each practitioner joining your practice. We cannot process your request for a contract without details on each practitioner.

If a practitioner is...	Then...
Already participating with Blue Cross	Send a <i>Contract Update Form</i> in order to join them to your group agreement. The form is on Provider Central at <a href="#">Forms&gt;Contract Updates</a> .
New to Blue Cross	Send a <i>Contracting Application</i> after they have updated their CAQH profile at <a href="https://proview.caqh.org">https://proview.caqh.org</a> . Download applications from Provider Central at <a href="#">Office Resources&gt;Enrollment&gt;Contracting Applications</a> .

## Release and representations by the practice

**Please read the following statements. You must sign and date this section before sending 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 and group practice named above.

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 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:

- Blue Cross's receipt of this application does not constitute approval or acceptance for network participation.
- My group practice cannot provide covered services and be reimbursed as a participating provider until Blue Cross notifies us that our contract is in effect, at which time this application will become part of our contract.
- If Blue Cross accepts my practice for participation, information provided on this application may be made available to members, prospective members, employers, brokers, other providers, and government regulators.
- My practice must immediately send a *Contract 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 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 on behalf of the practice by:**

Representative's signature \_\_\_\_\_

Print name

Business title

Email (required)

Business name

Date of signature \_\_\_\_\_


**Fax your completed, signed application to 1-617-246-4227. Keep a copy for your files.**

**Attach an IRS Form W-9 that is signed, dated, and completed with the name and tax ID number to which payments will be made. We cannot process your request without a W-9.**

If we send you a new contract:

- remember that only the authorized signer may sign the agreement
- refer to the cover letter we send you that includes detailed instructions on how to return your signed agreement.

\* 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.

# Request for Taxpayer Identification Number and Certification

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

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

<b>Print or type.</b>	<b>See Specific Instructions on page 3.</b>	<p><b>1</b> Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p> <hr/> <p><b>2</b> Business name/disregarded entity name, if different from above</p> <hr/> <p><b>3</b> Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC      <input type="checkbox"/> C Corporation      <input type="checkbox"/> S Corporation      <input type="checkbox"/> Partnership      <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p><b>Note:</b> 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 <b>not</b> 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.</p> <p><input type="checkbox"/> Other (see instructions) ▶ _____</p>	<p><b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p style="font-size: small;">(Applies to accounts maintained outside the U.S.)</p>
		<p><b>5</b> Address (number, street, and apt. or suite no.) See instructions.</p> <hr/> <p><b>6</b> City, state, and ZIP code</p> <hr/> <p><b>7</b> List account number(s) here (optional)</p> <hr/>	<p>Requester's name and address (optional)</p> <hr/>

## 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.

<b>Social security number</b>										
				-			-			
<b>or</b>										
<b>Employer identification number</b>										
				-						

## 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.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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## 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.*