Print form Clear form fields

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

## Psychiatrist, Psychologist, LADC-I, LICSW, LMFT, LMHC

# Contracting Application

Questions? Read our **Contracting Q & As**.

Complete this form online. Leaving blanks will delay processing.

**Fax completed form to 617-246-5053**

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.

Non-publicly available information that you designate as confidential in this application 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 in Office Resources>Enrollment>Credentialing & Recredentialing.

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 | • Update all information (including expired documents).<br>• Choose the option to authorize all healthcare organizations. This will allow us to access your information. |
| You're not a CAQH provider | • Log onto the CAQH website and self-register.<br>• Once registered, thoroughly complete your *Integrated Massachusetts Application* and submit all required documents. |
| 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.

### If you want a new contract for your group or solo practice, you must attach:

- A completed Practice Application (beginning on page 7)
- 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):

- ❑ **Licensed Alcohol and Drug Counselor I** (LADC-I)
- ❑ **Licensed Marriage & Family Therapist** (LMFT)
- ❑ **Licensed Mental Health Counselor** (LMHC)
- ❑ **Licensed Independent Clinical Social Worker** (LICSW)
- ❑ **Psychiatrist** (MD)
- ❑ **Child Psychiatrist** (MD)
- ❑ **Psychiatrist and Child Psychiatrist** (MD)
- ❑ **Psychiatrist and Neurologist** (MD)

**Clinical Psychologist**: ❑ PsyD ❑ EdD ❑ PhD ❑ Other ______________________________

| | |
|---|---|
| First name | |
| Last name | |
| National Provider Identifier (NPI Type 1) | |
| Social security number | |
| Date of birth | |
| Massachusetts license number | |
| New Hampshire license number | |

## 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) ______________________________

This practice will be your: ❑ Primary practice ❑ Secondary practice
(If you are not the practitioner, please verify before making a selection)

**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

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

Are you available to see Blue Cross members full time and year-round? ❑ Yes ❑ No

If no, please explain ______________________________________________

Are you:
❑ Accepting new patients
❑ Accepting existing patients only
❑ Closed (not accepting new patients and not accepting existing patients)

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

## 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 can only be those allowed by licensure. Covering providers must be participating in the same Blue Cross Products as your practice. Tell us which Blue Cross-credentialed practitioners or groups will provide coverage for you:

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

| | Name of practitioner (not yourself) or other group practice | NPI |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

To find covering providers, use our provider directory, Find a Doctor, at bluecrossma.com.

## 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.

- Child Psychiatrists: You may choose whether to participate in our Medicare Advantage Product.

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

- The following are ineligible for Medicare participation: Licensed Alcohol and Drug Counselors, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists.

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 1-617-246-5053. 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.

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

# Behavioral Health Professional Practice Application

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**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... |
|---|---|
| • Bills for practitioners' services on a CMS-1500 or 837P using an Employer tax ID, and<br>• Has not signed a Blue Cross behavioral health group contract, and<br>• Has not already completed a Behavioral Health Professional Practice Application for the tax ID number entered below | • Complete this entire Practice Application.<br>• Please send a form for each practice member. We cannot process your request for a contract without details on each practitioner. |
| • Is a solo practice | • Complete this Practice Application except for the sections on Practice members, Practice owners, and those authorized to sign. |

**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 | | | | |

**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

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

You must become a registered, active user of our secure website, 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 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 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 you, 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 behavioral health practitioners in the group must participate in the same Products; however,the following will not be enrolled in Medicare Advantage: Licensed Alcohol and Drug Counselors I, Licensed Mental Health Counselors, and Licensed Marriage and Family Therapists. Child Psychiatrists may choose whether to participate in Medicare Advantage.

Check the Blue Cross 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 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 *Contract Update Form* in order to join them to your group agreement. The form is on Provider Central at Forms>Contract Updates. |
| New to Blue Cross | Send a *Contracting Application* after they have updated their CAQH profile at https://proview.org. Download applications from Provider Central at Office Resources>Enrollment>Contracting Applications. |

## 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 1-617-246-5053. 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.

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.*