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

Ancillary Professional Providers

Contract Update Form

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

Send completed form to *BlueCrossContractOps@bcbsma.com* or fax 617-246-5053.
If emailing, please include practitioner's *Last Name, First Name* in the Subject.

Use this form to notify Blue Cross* of a change to a contracted practitioner's practice status, etc. Keep a copy of this completed form for your files. If needed, you will receive a new contract for signature.

You cannot provide covered services and be reimbursed as a participating provider in any new practice or new Product until you are notified by Blue Cross that the new contract is in effect.

Check all that apply:	**And complete these sections:**
❑ Leaving your current practice and joining a new practice that will bill for your services on a CMS-1500 or 837P	1, 2, 3, 4, 6, 7, 9, 10
❑ Staying with your current practice and joining a new practice	1, 4, 5, 6, 7, 9, 10
❑ Opening a practice	1, 2, 4, 5, 6, 7, 8, 9, 10, Group Practice Attachment
❑ Changing your practice's Tax ID number	1, 5, 8, 9, 10, Group Practice Attachment
❑ Changing your practice availability	1, 5, 7, 9
❑ Want to add add a Product to your Agreement	1, 2, 5, 9, 10

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, we will enroll you in the same Products as the group.
- If you are remaining as an independently practicing provider only, please check **all** Products in which you wish to participate.

❑ HMO ❑ PPA/PPO ❑ Indemnity ❑ Medicare Advantage HMO ❑ Medicare Advantage PPO

* 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 Product participation associated with that practice. You must indicate in section 2 the Products in which you now wish to participate.

If you are leaving your primary contracted group, they will need to submit a termination in order to remove their group contract from your profile.

If leaving all Blue Cross practices, please submit the *Standardized Provider Information Change Form* instead of this form.

Date leaving practice _____

Practice name _____

Practice's NPI (Type 2) _____

Practice location _____

City, state, ZIP _____

Phone ( ) _____

Section 4. Joining or opening a new practice

If your group has a new Tax ID and Type 2 NPI, please also complete the Group Practice Attachment on page 4.

Please verify with practitioner and check one. This will be the practitioner's: ❑ Primary practice ❑ Secondary practice

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

Employment or start date _____

Practice name _____

DBA (as reported to the IRS) _____

Practice's tax ID number _____

Practice's NPI (Type 2 if group) _____

Practice location* _____

City, state, ZIP _____

Phone to schedule appointments ( ) _____ Fax ( ) _____

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

*Practice locations are where patients can make an appointment to see you. Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Additional 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 _____

Email _____

Phone ( ) _____ Fax ( ) _____

Chiropractors, Optometrists, and Podiatrists Who Bill for Diagnostic Imaging Services

If the practice intends to begin billing Blue Cross for diagnostic imaging services (professional and/or technical component), please download the appropriate privileging application from bluecrossma.com/provider. In Office Resources, click Privileging.

Even if a practitioner has technical component privileges at another practice, they must obtain privileges for a new practice by submitting an application. However, when a practitioner intends to continue billing for the same professional component services and **does not** intend to bill any technical component services at a new practice, they do not need to submit any privileging applications.

Podiatrists

Please select one:

❑ You are a **non-surgical** podiatrist

❑ You are a **surgical** podiatrist with privileges in good standing at an acute care hospital or ambulatory surgery center that participates with Blue Cross.

Name of hospital or ASC: _____

Section 5. Existing practice

Please verify with practitioner and check one. This is the practitioner's: ❑ Primary practice ❑ Secondary practice

Practice name _____

DBA (as reported to the IRS) _____

Practice's tax ID number _____

Practice's NPI (Type 2 if group) _____

Practice location* _____

City, state, ZIP _____

Email _____

Phone to schedule appointments ( ) _____ Fax ( ) _____

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

*Practice locations are where patients can make an appointment to see you. Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

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

Section 6. Covering arrangements

Blue Cross agreements require that providers maintain arrangements to render care as needed when they are unavailable.

❑ I attest that I have covering arrangements in place to ensure my patients have access to care when I am unavailable, in keeping with industry standards for my profession.

Section 7. Changing practitioner availability status

This section is optional for CRNAs

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

❑ Accepting new patients
❑ Not accepting new patients

Will you offer telehealth? ❑ Yes ❑ No

❑ 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 _____

Section 8. New IRS Form W-9

A new W-9 is required to verify new billing information. If you are joining a contracted group, you do not need to attach a W-9.

❑ The attached IRS Form W-9 has been completed with the name and Tax ID number to which payments will be directed.

Section 9. Representations

❑ By checking this box, you hereby affirm and represent that all statements, answers, and information included in this Contract Update Form are true and complete to the best of your knowledge and belief, and that you are duly authorized to provide information on behalf of the practitioner named in section 1.

Name of person completing form _____

Business title _____

Company name _____

Email _____

Phone ( ) _____ Fax ( ) _____

Date _____

Section 10. Contract recipient

If we need to send you a new contract Attachment A, we must email it ***directly to you (the practitioner)*** for signature. You are required to personally sign a new Attachment A to be legally bound to the practice's Agreement. Be sure to use an active email you check regularly.

Practitioner's email (required): _____

You will receive a welcome letter showing the date you may begin treating our members at the new practice.

Email for welcome letter (required): _____

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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

If we need to send you 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.*

Name and business title _____

Email (required) _____

Please remember that only this person may sign the agreement we send you.

Practice owner(s)

_____

_____

_____

_____

Practice Members

- Please list all clinicians in the practice who have the licensure indicated in section 1. Attach an additional sheet if needed.
- Each clinician who is **new to Blue Cross** must complete a *Contracting Application* for their licensure. Applications are available on Provider Central at Forms>Contracting Applications.
- Each clinician who is **currently participating with Blue Cross** must complete a separate *Contract Update Form for Ancillary Professional Providers*, available on Provider Central at Forms>Contract Updates.

Clinician Name	NPI (Type 1)	Primary or Secondary with this group

Additional Practice Locations for Appointments

Practitioner		NPI (Type 1)	
Practice name		**Practice NPI (Type 2)**	

The above is your: ❑Existing practice ❑A practice you are joining or opening

Only locations where patients can make appointments to see you will be displayed in our provider directory, *Find a Doctor & Estimate Costs*.

We require a complete list of these locations, but please note that only five addresses *(including the practice address you entered on page 2 or 3 of this form)* will be displayed in the directory.

For each address below, please check one box:

- **Appointments** – You see patients at this address, and they can make an appointment to see you here
- **Visits** – You see patients at this address but not by appointment *(listing these is not required)*
- **Covering** – You cover or fill-in at this address *(listing these is not required)*
- **Tests** – You read tests or perform imaging at this address *(listing these is not required)*

For the practice and NPI above, please list all additional locations *where patients can make appointments to see you.* How many copies of this page have you attached to the Update Form?

Location name

Address

City, state, ZIP

Phone to schedule appointments Fax

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name

Address

City, state, ZIP

Phone to schedule appointments Fax

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name

Address

City, state, ZIP

Phone to schedule appointments Fax

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name

Address

City, state, ZIP

Phone to schedule appointments Fax

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

Location name

Address

City, state, ZIP

Phone to schedule appointments Fax

Check one (required) ❑Appointments* ❑Visits* ❑Covering ❑Tests

*Each location must have a separate, designated space for providing care to patients, ensuring privacy during treatment.

Please notify us if the above information changes.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

Sign Here	**Signature of U.S. person ▶**	**Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.