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

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

Contract Update Form

Questions? Write *ProviderApplicationStatus@bcsma.com* or call 1-800-316-BLUE.

Send completed form to *NetworkManagement@bcbsma.com* or fax 1-617-246-4227.
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 NPPCP's or PAPCP's practice status, etc. as listed below. Please retain a copy of this completed form for your files. If needed, a new contract will be mailed for you to complete and return.

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

Check all that apply:	**And please complete these sections:**
❑ You are an NPPCP or PAPCP leaving your current practice and joining a new practice, as a primary care provider, that will bill for your services on a CMS-1500 or 837P	All sections except 5, 10, 11
❑ You are an NPPCP or PAPCP changing your designation to NP or PA	Please do not submit this form. Instead, download the **Contract Update Form for Physician Assistants and Ancillary Advanced Practice Nurses** by logging onto bluecrossma.com/provider. Go to Forms > Forms Library > Contract Updates.
❑ You are changing your practice's Tax ID number	1, 5, 11, 12, 13, Group Practice Attachment
❑ You wish to add a Product to your Agreement	1, 2, 5, 6, 12, 13
❑ You are changing your Collaborating or Supervising Physician	1, 5, 6, 7, 8, 13
❑ You are changing your practice availability	1, 5, 9, 12
❑ You are changing your specialty	1, 5, 6, 9, 10, 12
❑ You are changing your hospital affiliation	1, 5, 8, 12

Section 1. Individual Practitioner Information

Name: ______________________

License number: ______________________

National Provider Identifier (NPI Type 1): ______________________

Email: (required) ______________________

Check one: ❑ Nurse Practitioner-Primary Care Provider ❑ Physician Assistant-Primary Care Provider

Check your specialty: ❑ Family Medicine ❑ Internal Medicine ❑ Pediatrics

Section 2. Blue Cross Product Participation

- To add a Product, please check **all** Products that you want to participate in.
- If you are joining a group practice, you must be enrolled in the same Products that the group participates in.

  However, if your specialty is limited to pediatrics, enrollment in Medicare Advantage is optional.
- 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 NPI (Type 2): ____________________

Main practice location: ____________________

City, State, Zip code: ____________________

Phone: (   ) ____________________

Section 4. Joining or Opening a New Practice as a Primary Care Provider

In section 2, please indicate the Products you wish to participate in at this practice.

Please note: You may be contracted with Blue Cross as a PCP at one practice only. However, you may be contracted with Blue Cross as an NP or PA in primary care or specialty care at an additional practice.

If your group has a new Tax ID and Type 2 NPI, please also complete the Group Practice Attachment (2nd to last page of this form).

Employment or start date: ____________________

Practice name: ____________________

DBA (as reported to the IRS): ____________________

Practice Tax ID number: ____________________

Practice NPI (Type 2): ____________________

Main practice location: ____________________

City, State, Zip code: ____________________

Phone to schedule appointments: (   ) ____________________ Fax: (   ) ____________________

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

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

Billing address ❑ Same as above ❑ Other:

Billing name: ____________________

Address: ____________________

City, State, Zip code: ____________________

Email: ____________________

Phone: (   ) ____________________ Fax: (   ) ____________________

Section 5. Existing Practice

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

Practice name: ______________________________

DBA (as reported to the IRS): ______________________________

Practice Tax ID number: ______________________________

Practice NPI (Type 2): ______________________________

Main practice location: ______________________________

City, State, Zip code: ______________________________

Email: ______________________________

Phone to schedule appointments: (   ) ______________ Fax: (   ) ______________

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

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

Section 6. Collaborating Arrangement *This section is required if you are joining or opening a practice.*

To be completed by NPPCPs:

☐ I comply with all requirements of the Mass. Department of Public Health as an Advanced Practice Nurse with **more** than two years of experience. (No need to submit collaborating physician information)

☐ I comply with all requirements of the Mass. Department of Public Health as an Advanced Practice Nurse with **less** than two years of experience. My collaborating physician information is below:

Name of physician	Specialty	NPI Type 1	Hospital affiliation

To be completed by PAPCPs:

☐ I comply with all requirements of the Mass. Board of Registration in Nursing. (No need to submit supervising physician information)

Section 7. Covering Arrangement *This section is required if you are joining a practice.*

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

Physician or Group Practice Name	NPI

Section 8. Changing Hospital Affiliation and Admitting Privileges

Your hospital affiliation must be a Blue Cross contracted acute care hospital and your admitting provider must be a Blue Cross credentialed and contracted physician or a hospitalist program.

☐ Changing your primary hospital affiliation ☐ Adding a secondary hospital affiliation

Name of hospital (required): ______________________________

This section continues on next page

Initial date of appointment (MM/DD/YY): ____________________

Do you have admitting privileges at this hospital? ❑ Yes ❑ No

If you do not have admitting privileges at the above hospital, please indicate who arranges for your inpatient admissions and enter name(s) below. This arrangement will continue until you notify Blue Cross of a change.

❑ Your Collaborating Physician (NPPCPs)

❑ Physicians in your practice

❑ Physicians not affiliated with your practice

❑ Hospitalist program

Name of physicians, practice, or hospitalist program checked:

____

Section 9. Changing Practitioner Availability Status

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 10. Changing Your Specialty

Check your specialty: ❑ Family Medicine ❑ Internal Medicine ❑ Pediatrics

NPPCPs: Indicate the new certifying body (AANP, ANCC, NCC, or PNCB) and attach a copy of your certificate: ____________

Section 11. New Form W-9

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

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

Section 12. Representations

❑ By checking this box, you hereby affirm and represent that all statements, answers, and information 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 clinician named in section 1.

Name of person completing form: ______________________________

Title: ______________________________

Business name: ______________________________

Email: ______________________________

Phone: (   ) ____________________ Fax: (   ) ____________________

Date: ______________________________

Section 13. Contract Recipient

Each practitioner is required to personally sign a new Attachment A to be legally bound to the practice's Agreement. Be sure to use an active email you check regularly.

Practitioner's email (required): ______________________________

You will receive a welcome letter showing the date you may begin treating our members at the new practice. Email to receive the welcome letter (required): ______________________________

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Group Practice Attachment

Only complete this page if you are opening a new practice with a Type 2 NPI.

Practice Administration

Please list those who are authorized to sign contracts on behalf of the practice, such as Owner, Partner, President.

Name and title	Email (required)

Practice owner(s)

____

____

____

____

Practice Members

- Please list all NPs and NPPCPs – or PAs and PAPCPs, as applicable – in the group. Attach an additional sheet if needed.
- Each clinician who is **not currently participating with Blue Cross** must complete a Contracting Application. You can download the application at bluecrossma.com/provider. Under Forms, click Forms Library > Contracting Applications.
- Each clinician who is **currently participating with Blue Cross** must complete a separate Contract Update Form for NPPCPs and PAPCPs. Go to bluecrossma.com/provider. Under Forms, click Forms Library > Contract Update Forms.
- These clinicians must be enrolled in the same Products as the group. However, if their specialty is limited to pediatrics, they may choose whether to participate in Medicare Advantage.

Practitioner Name	NPPCP or PAPCP	NPI (Type 1)	Participate in Medicare Advantage? Y/N

Additional Practice Locations

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

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

For the practice and NPI above, we require a complete list of locations where you will or do provide services.

How many copies of this page have you attached? ____

Please note that only five locations (*including your primary practice location*) will be displayed in our provider directory, *Find a Doctor & Estimate Costs*. Only locations where patients can make appointments to see you will be displayed.

For each address, please check one box:

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

Location name			
Address			
City, state, ZIP			
Phone to schedule appointments		Fax	

Check one (required) ❑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. 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.*